TREATING BINGE EATING DISORDER: A PSYCHOEDUCATIONAL PROGRAMME TEACHING EMOTIONAL DISCRIMINATION AND MANAGEMENT

BY

NATASHA JAYNE WALLIS

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ABSTRACT

There is a vast amount of literature concluding that some form of emotional distress precedes binge-eating episodes. Such evidence makes accountable this current research - to design and implement a psychoeducational group programme to teach emotional discrimination and management for women with binge eating disorder. Three women participated in the programme, with three women used as a control group. The programme consisted of eight sessions run over six weeks and involved monitoring, learning how to better recognize emotions and learning techniques to manage emotions through relaxation techniques, problem solving skills, self-regulation writing and assertion training. Results showed some positive changes on the Eating Disorder Inventory-2, the Emotional Eating Scale, the Beck Depression Inventory, the Beck Anxiety Inventory and the Cope Scale, in comparison to the control group. Implications for future research in the area of binge eating and emotion are discussed.

CHAPTER ONE: INTRODUCTION AND LITERATUE REVIEW

"It is easy to convince yourself on the day after each binge that that was the last one, and as of today you are never going to binge again. Unfortunately the nausea and feeling of self-revulsion disappears after a few days, and before you know it, the idea of escape into a session of eating unlimited amounts of anything that takes your fancy gets hold of you again. This can be caused by boredom, anxiety, or just to relax or escape for a while" (Abraham and Llewllyn-Jones, 1995, p. 105-106).

1.2. BINGE EATING – AN OVERVIEW

Binge eating is recognized as a significant clinical problem in our society. Recently a diagnosis has been developed to categorize those individuals who have problems with recurrent binge eating (Diagnostic and Statistical Manual; American Psychiatric Association [APA], 1996). Binge eating is the consumption of a large amount of food in a relatively short period (see Table 1 for full description). Although bingeing is a common component found in the eating disorders of anorexia nervosa and bulimia, binge eating disorder is not associated with the compensatory behaviours found in these disorders (e.g., purging, fasting, excessive exercise or the use of laxatives). It is primarily the experience of loss of control over eating, and not the amount consumed,

which is the important feature (Fairburn and Wilson, 1993; Garner, Shafer, and Rosen, 1992; Beglin and Fairburn, 1992).

1.2.1. Table 1: Criteria for Binge Eating Disorder

A. Recurrent episodes of binge eating. An episode of binge eating is characterized by both of the following:

   (1) Eating, in a discrete period of time (e.g., within any 2-hour period), an amount of food that is definitely larger than most people would eat in a similar period of time under similar circumstances.

   (2) A sense of lack of control over eating during the episode (e.g., a feeling that one cannot stop eating or control what or how much one is eating).

B. The binge-eating episodes are associated with three (or more) of the following:

   (1) Eating much more rapidly than normal.

   (2) Eating until feeling uncomfortably full.

   (3) Eating large amounts of food when not feeling physically hungry.

   (4) Eating alone because of being embarrassed by how much one is eating.

   (5) Feeling disgusted with oneself, depressed, or guilty after eating.

C. Marked distress regarding binge eating is present.

D. The binge eating occurs, on average, at least 2 days a week for 6 months.

E. The binge eating is not associated with the regular use of inappropriate compensatory behaviours (e.g., purging, fasting, excessive exercise) and does not occur exclusively during the course of Anorexia Nervosa or Bulimia Nervosa.

1.2.2. PREVALENCE

Binge eating disorder appears to have slightly higher prevalence rates than bulimia nervosa, of approximately 2 to 3% reported in community samples (Spitzer, Devlin, Walsh, Hasin, Wing, Marcus, Stunkard, Wadden, Yanovski, Agras, Mitchell, and Nonas, 1992; Yanovski, Nelson, Dubbert, and Spitzer, 1993). Binge eating disorder is more common among overweight individuals, with data indicating that 5 to 8% of obese individuals in the community meet criteria for the disorder (Bruce and Agras, 1992).

Research has identified binge-eating patterns in 20% to 55% of overweight individuals seeking treatment. A study involving 112 overweight men and women seeking treatment for obesity (Gormally, Black, Daston, and Rardin, 1982), found 55% with moderate problems with binge eating and 23% with very severe problems with binge eating. In another report (Marcus, Wing and Lamparski, 1985), 46% of 432 overweight women seeking treatment for weight loss, were found to have serious problems with binge eating. A survey of 280 obese men and women seeking treatment for weight reduction, found 28.6% reporting bingeing at least twice a week and an additional 22.1% binged at least once weekly (Telch, Agras, Rossiter, Wilfrey and Kenardy, 1990).

In a study of 70 obese subjects who were not in a weight loss treatment program 33% exhibited binge eating patterns according to a modified Diagnostic and Statistical Manual of Mental Disorders, 3rd. ed., criteria for bulimia, suggesting that binge eating may be prevalent in the nonclinical obese population. In addition, binge eating appears to increase in prevalence with increasing body fat (Telch, Agras and Rossiter,

1988), with heavier patients scoring higher on binge severity scores (Kolotkin, Revis, Kirkley and Janick, 1987). Thus a large number of overweight individuals appear to suffer from binge eating problems (Telch, Agras, Rossiter, Wilfrey and Kenardy, 1990).

Most clinical population studies have reported the mid 40s as a mean age for individuals suffering from binge eating disorder (e.g., Arnow, Kenardy and Agras, 1992; McCann, Rossiter, King and Agras, 1991). In community samples however, the age tends to be from the late 20s to mid 30s (Spitzer, Devlin, Walsh, Hasin, Wing, Marcus, Stunkard, Wadden, Yanovski, Agras, Mitchell and Nonas, 1992). Such data suggests that individuals have suffered from the disorder for some time prior to seeking treatment (Castonguay, Elderedge and Agras, 1995).

A Christchurch study (Fear, Bulik and Sullivan, 1996) involving 363 adolescent girls found that 36% reported having an episode of binge eating and had binged on average twice a week. Other research examining weekly bingeing in this age group found a 17% prevalence rate (Johnson, Lewis, Love, Lewis and Stuckey, 1984; Moss, Jennings, McFarland and Carter, 1984). Two explanations were given for this difference. The difference here may have been due to asking about *ever* bingeing as opposed to *weekly* binge. It may also be in part due to the definition of binge used. Binge eating in general refers to the consumption of an *objectively* large amount of food along with a sense of loss of control over the eating. A *subjective* binge is if the amount of food eaten is not unusually large by social comparison (Beglin and Fairburn, 1992). It can be unclear as to whether subjects report both objective and subjective binges. This may be irrelevant, however high rates of either are of concern.

High rates of objective binge eating suggest an individual has a well-developed eating disordered pattern. High rates of subjective binges on the otherhand, may be an indication that an individual has developed cognitive distortions about eating and may be at risk of further developing restrictive eating in addition to future objective binges (Fear, Bulik and Sullivan, 1996).

1.2.3. EMOTIONS AND BINGE EATING

There is much research (Bruch, 1969; Heatherton, 1991) that suggests binge eating episodes are proceeded by some form of emotional distress and that those who binge tend to have limited ability in recognizing and coping with emotional arousal. The diagnostic category of binge eating was only introduced in 1996 and evidence which links binge eating episodes to emotional distress precedes this date, meaning that many of the participants in these earlier studies may well have been sufferers of anorexia nervosa or bulimia nervosa who exhibited binge eating. However, there are good theoretical reasons as well as the empirical data mentioned to hypothesize a link between emotional distress and binge eating for those individuals diagnosed solely as binge eaters.

Important publications such as *"Binge Eating: nature, assessment and treatment"* (Fairburn and Wilson, 1993) mention stress and negative affect as instigators of a binge episode, but treatment for binge eating disorder continues to take the form of treatment procedures modified from cognitive-behavioural treatment approaches for bulimia and anorexia. Few treatments focus specifically on teaching individuals effective ways of dealing with their emotions.

This thesis first looks at the current knowledge of and literature about the treatment of binge eating, then develops and examines the effectiveness of a psychoeducational group program that teaches emotion discrimination and management for the treatment of binge eating disorder.

1.2.4. CURRENT TREATMENTS FOR BINGE EATING DISORDER

Research on the treatment of binge eating and bulimia nervosa has developed greatly in the last 10 years, however many of the original studies focus on the more dramatic behaviour of purging rather than on what is generally considered today to be the centrally important behaviour, namely binge eating. The fact that treatments effective in bulimia nervosa are effective in those who binge eat (McCann and Agras, 1990; Telch, Agras, Rossiter, Wilfrey, and Kenardy 1990; Smith, Marcus, and Kaye, 1992) suggest that binge eating and bulimia nervosa may be aspects of the same core disorders (Fairburn and Wilson, 1993).

Three major approaches stand out in terms of understanding and treating binge eating disorder: cognitive-behavioural, interpersonal, and pharmacological. These have been derived from previous theories and treatments established for bulimia nervosa (Castonguay, Elderedge, and Agras, 1995). However most models of binge eating are more partial than complete and only attempt to address subgroups of sufferers (McManus and Waller, 1995), such as obese binge eaters, nonpurging bulimics and dieters.

Cognitive-behavioural approach The concept of binge eating was first noted in obesity by Stunkard (1959). It was not until Fairburn's development of a cognitive-behavioral model of bulimia nervosa that real efforts were made to address binge eating in obesity. The cognitive behavioural model of binge eating disorder based on Fairburn's model of the syndrome of bulimia nervosa (Fairburn 1981, 1985) places importance on self-esteem, which leads to weight and shape concerns. It is these concerns that are thought to motivate dieting and restrained eating and both the psychological and physiological stress that this places on the individual contributes to a cyclic pattern of binge eating and renewed efforts at dieting. No suggestions are given, however, as to what the antecedents are for the low self-esteem, or why all those individuals with low self-esteem do not follow this cycle (McManus and Waller, 1995). It is however one of the best described as to its procedures, and the most frequently studied in controlled trials.

Cognitive-behavioural treatment is typically structured in 3 phases. The first phase places emphasis on the cognitive view of the maintenance of the disorder. This is illustrated in Figure 1. In addition, behavioural strategies are introduced to help patients reestablish control over their eating. The second phase introduces problem-solving and cognitive techniques to assist patients in managing remaining triggers for binge eating in addition to dysfunctional attitudes toward weight and shape. There is particular emphasis on the elimination of dieting. The third phase focuses on maintenance of change following treatment and on relapse prevention (Fairburn, Marcus, and Wilson, 1993).

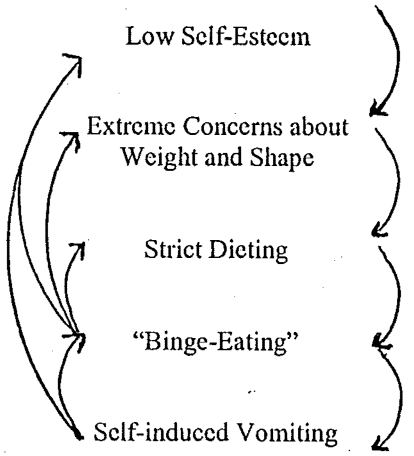

Figure 1. The cognitive view of the maintenance of bulimia nervosa.

Restrained eating patterns Food restriction and dietary restraint have been the primary focus of research for this model (Castonguay, Elderedge, and Agras, 1995). Correct and adequate knowledge of food and the overall value of eating a well-balanced, varied and nutritional diet is lacking for binge eaters. They have a tendency to eliminate certain foods from their diets, as they are perceived as "fattening". Generally, they have a distorted view of the caloric value of food in that they do not accept or understand that a calorie is a calorie whether it is contained in a protein, carbohydrate, or fat food group. Some binge eaters who deny themselves certain foods tend to experience strong feelings of deprivation relating to these foods. Over time these "forbidden foods" become increasingly attractive and often become the foods binge eaters choose for binge episodes (Hawkins, Fremouw and Clement, 1984). Beebe (1994) argued that although restraint hypothesis models explain the

disruption of restraint that occurs during bingeing, they do not explain the motivation behind the bingeing or what benefits this behaviour has.

"I think that I look forward to a binge eating session. Exactly what I am thinking is vague but on reflection it is: Oh good, I won't have to think about dieting any more – what a relief!" (Abraham and Llewllyn-Jones, 1995, p. 102).

Compulsive overeaters often have a history of dieting. They diet and feel miserable, then they eat and feel better. Their dieting however makes their metabolism grow increasingly sluggish. Eventually weight loss becomes associated with control and weight gain with out-of-control behaviour (Pipher, 1994).

Binge eaters' eating behaviours are often irregular, bizarre and extreme. Included are skipping meals, fasting for short periods, adhering to one or two food regimes, and following fad diets. Their behaviours are short-lived as they result in uncomfortable physical or psychological side effects such as dizziness, headaches, and diarrhea or a sense of boredom or deprivation (Hawkins, Fremouw and Clement, 1984).

There is clinical evidence that binge eating is proceeded by dieting, although the role of restraint in binge eating disorder may be limited. More so, is the evidence of greater preoccupation and distress over eating, and accordingly, those with binge eating disorder report a grater number of attempts at dieting (Spitzer, Devlin, Walsh, Hasin, Wing, Marcus, Stunkard, Wadden, Yanouski Agras, Mitchell, and Nonas, 1992). Data suggests for binge eating disorder it may be the chaotic eating patterns

which play the larger role in promoting binge eating than efforts to restrain. More research needs to be done to confirm this link (Castonguay, Eldredge, and Agras, 1995).

Weight and shape concerns In the cognitive behavioural model of bulimia nervosa, weight and shape concerns are thought to be the driving force behind the dieting which in turn sets the stage for binge eating (Castonguay, Eldredge, and Agras, 1995). Unreasonable expectations are held on the daily effects of dieting on body weight and fat disposition, with rigid belief that there is a one-to-one ratio between what is eaten and how weight is affected. Beliefs such as that food turns to fat on their bodies shortly after consumption lead to weighing immediately after eating to note the weight gain. Also, the subjective sense of being full, generates a belief that they are now fatter than before they ate. Moderation in food consumption and flexibility in food choice is simply not an option (Hawkins, Fremouw, and Clement, 1984). But little focus has been placed on weight and shape concern and their role in binge eating disorder. In general research indicates (Wilson Nonas and Rosenblum, 1993; Eldredge and Agras, 1994) that those with binge eating disorder report more height, weight and shape overconcern that individuals without binge eating disorder, but they show less concern (Marcus, Smith, Santelli, & Kaye, 1992) than individuals with bulimia nervosa.

The escape model of binge eating Recently a cognitive behavioural model has also described binge eating as an avoidance coping response to prevent painful self-awareness (Heatherton and Baumeister, 1991). Research has shown that there is a relationship between avoidance coping and disordered eating (Lackner, 1992;

Lehnman and Rodin, 1989; Mayhew and Edelmann, 1989; Troop, Holbrey, Trowler and Treasure, 1994). Heatherton and Baumeister's (1991) cognitive-behavioural model is relevant to this. The escape model states that binge eaters have very high standards and expectations and when they fall short of these, it creates painful self-awareness. As an attempt to escape from this self-awareness, they narrow their focus enough to avoid meaningful thought. Although it is difficult to turn off one's awareness of self, a common strategy is to narrow one's focus of attention to the present and immediate stimulus environment. Such cognitive narrowing disengages eating inhibitions resulting in binge eating and a susceptibility to irrational beliefs and thoughts (Castonguay, Elderedge, and Agras, 1995; Heatherton and Baumeister, 1991). There is evidence that supports the six steps of the model (high standards and expectations; high and aversive self-awareness; negative affect; cognitive narrowing; removal of inhibitions; irrational beliefs) and there do not seem to be any major sets of findings that are incompatible with escape theory. Rather than focus on predisposing and possible consequences of the disorder, the theory is an attempt to explain the process of bingeing (Heatherton and Baumeister, 1991) (although predisposing factors are implicit in the model).

Indeed, binge eaters tend to engage in perfectionism and all-or-none thinking, for example, striving to adhere rigidly to their diet and experiencing intense disappointment if they fail to follow their diet perfectly. The experience of going slightly off the diet is followed by disappointment in not measuring up to their high standards and results in a full-blown binge. Binge eaters continually set themselves up for disappointment. The result is a self-perpetuating and self-defeating cycle of behaviour (Hawkins, Fremouw and Clement, 1984).

High levels of perfectionism are typical in women with anorexia and/or bulimia nervosa (e.g., Garner, Olmsted and Polivy, 1983; Thompson, Berg and Shatford, 1987). Steiner-Adair (1986) found that all girls had a similar image of the ideal women. But when comparing personal goals with scores on the Eating Attitudes Test it was found that those girls who internalized the 'superwoman' ideal into their personal goals, had higher eating pathology score than those girls whose personal goals were less ambitious (Archer, 1996).

However, in this escape model authors use the term binge eating to refer to eating that results from disinhibition of dietary restraint whether or not it is a part of a broader pattern of bulimia. It has been well established that binge eating often occurs in the context of dieting and weight concern, but this theory, like many, does not take into account binge eaters who do not diet.

Implications for treatment are developing interactions for modifying binge eaters' high standards and expectations, reducing self-hatred, raising self-esteem, and use of cognitive therapy to eliminate negative thinking about the self (Castonguay, Elderedge, and Agras, 1995).

Castonguay, Elderedge and Agras (1995) propose a model that hypothesizes that low self-esteem gives rise to both weight and shape overconcern, and negative affect. As with bulimia nervosa, weight and shape concerns influence efforts of dieting, setting the stage for binge eating prompted by physiological and cognitive factors. As it is known that binge-eating-disordered individuals suffer high lifetime rates of depression, they suggest that binge eating serves, in part, as an avoidant coping

response to negative effect, which then acts as a negative reinforcer for binge eating behaviour. Either triggered by negative affect or prompted by dieting, binge eating further erodes self-esteem and contributes to both dieting and negative affect in a manner which exacerbates the problem (Castonguay, Elderedge, and Agras, 1995).

Cognitive-behavioural treatment (CBT) for binge eating disorder While there are doubts as to how well the cognitive behavioural model for bulimia nervosa fits binge eating disorder, its applications have had encouraging results. In an uncontrolled study, CBT was administered in a group format to eight women who were obese binge eaters. The mean reduction in objective and subjective binge eating episodes combined, after sixteen 90-minute sessions, was 81% with 80% abstinence rate. Weight and shape concerns also improved (Smith, Marcus, and Kaye, 1992).

Agras and colleagues conducted a group CBT with nonpurging bulimics. Forty-four women were randomized to either a 10-week group CBT condition or a waiting list. CBT subjects experienced a decrease in the frequency of binge eating of 94%, with 79% reporting abstinence at post-treatment. Wait-list control subjects reduced their binge eating by 9% and then received the CBT treatment package, which resulted in an 85% decrease in the frequency of binge eating with 73% reporting abstinence. A follow-up evaluation was conducted with subjects in the initial CBT group after 10 weeks. Frequency of binge eating had reduced to 69% that of baseline, with abstinence rates decreasing to 46% (Telch, Agras, Rossiter, Wilfrey, and Kenardy, 1990).

Results for cognitive behavioural treatment suggest that short-term CBT is effective in significantly reducing the frequency of binge eating and abstinence for binge eating disorder patients.

Interpersonal approach (IPT) This approach is based on the idea that interpersonal problems are a critical source of low self-esteem and in turn negative affect which triggers binge eating (Agras, 1991). The treatment is aimed at enhancing interpersonal functioning in the areas of interpersonal deficits, disputes, role transitions, and unresolved grief. If improvements are made in these areas then this is enough to eliminate problematic eating behaviour (Castongyuay, Elderedge, and Agras, 1995). IPT is a focused, time-limited form of therapy originally developed for the treatment of depression (Kerman, Weissman, Rounsaville, and Chevron, 1984), adapted successfully to the treatment of bulimia nervosa. It consists of three stages. In the first stage, interpersonal difficulties involved in the development and maintenance of the eating disorder are identified. In the second stage, a contract is made to work on these problems and they become the focus of treatment. In the third stage, issues of termination are addressed.

Interpersonal treatment (IPT) for binge eating disorder Although the approach has not been directly tested on its theoretical components, a few studies have evaluated the efficacy of IPT with nonpurging binge eaters. Wilfrey and colleagues (1993) compared group administered IPT to CBT and a wait-list control condition. After 16 weeks of treatment, IPT subjects reduced the frequency of their binge eating by 71% with 44% of subjects reporting abstinence, and those on the wait-list had a 10% reduction in binge eating with no subjects achieving abstinence. The frequency of

binge eating was reduced from baseline by 50% for IPT subjects and 55% for CBT subjects at one-year post-treatment (Wilfrey, Agras, Telch, Rossiter, Schneider, Cole, Sifford, and Raeburn, 1993).

Another study, this time with overweight binge eaters, examined whether IPT might be effective for patients who fail to respond to CBT. Those who were not abstinent from binge eating after 12 weeks of CBT received IPT in a group format for an additional 12 weeks. Following this time binge eating increased from 2.9 days/week to 3.8 days/week with no subjects achieving abstinence (Agras, Telch, Arnow, Elderedge, Henderson, Marnell, in press; Castonguay, Elderedge, and Agras, 1995).

These two studies suggest that IPT administered in a group format can be expected to have results comparable to that of CBT.

Biological approach There are two theories with a biological perspective. The first is a psychobiological model recently proposed by Blundell and Hill (1993). In this model, the appetite control system is seen as a synchrony of behavioural, physiological, and neurochemical events. Disruption can occur to the synchrony of the system by either intrinsic (e.g., a defeat of physiology or neurochemistry) or extrinsic factors which could be mild or severe. Mild for example would be the confusion of tasted metabolism conditioning. This is where appropriate anticipatory responses to be generated to the taste of food, are undermined by the appearance in the food supply of consumables with identical tastes but differing metabolic properties. Severe disruption will occur with extrinsic factors such as severe dieting,

prolonged fasting, and vomiting (Fairburn and Wilson, 1993). Once binge eating occurs, desynchrony is created throughout the appetite control system.

Research shows that such desynchrony among those with eating disorders exists and the implication of this theory is that disordered appetite implies loss of synchrony. Thus, the chaotic eating pattern shown by binge eating disorder patients is associated with desynchrony among the components of the appetite control system (Blundell and Hill, 1993). Desynchrony does exist in eating disordered patients between eating behaviour and subjective motivation (Owen, Halmi, Gibbs, and Smith, 1985) and between behaviour and peripheral variables such as plasma amino acid ratios as well as central indices such as neurotransmitter metabolites in cerebrospinal fluid (Kaye, Ebert, Gwirtsman and Weiss, 1984). In addition it has been suggested that there is a serious dysregulation of serotonin in eating disorders (Brewerton, Muller, Brandt, Lesem, Hegg, Murphy, and Jimerson, 1989; Blundell and Hill, 1990). This assertion has not been investigated and no specific treatment has been derived at this time from this model (Castonguay, Elderedge, and Agras, 1995), however treatment would involve resynchronization of events at the three levels. Pharmacological agents acting on central neuromodulators would regulate the pattern of eating (Blundell, 1990).

The second theory has been derived by viewing bulimia nervosa as a form of affective disorder. This has been hypothesised because bulimia (and binge eating disorder) have high levels of comorbidity with depression, and antidepressants have been shown to be effective in the treatment of binge eating. However there are a number of problems with this hypothesis, chiefly that changes in psychopathology appear to follow reductions in overeating occasioned by the introduction of medication. Similar

effects are seen with very different pharmacological properties, and relapse occurs while on medication. Laessle and colleagues through a series of experiments looked at the correlation of eating disorders and affective disorders. They concluded that depression is probably not the primary disorder underlying eating disorders (Laessle, Schweiger, Fichter, Pirke, 1988), so the theory that bulimia is a form of affective disorder, for these and other reasons, is not widely accepted any more (Castonguay, Elderedge, and Agras, 1995; Fairburn and Wilson, 1993).

Pharmocalogical treatment of binge eating disorder Despite the lack of support for this model, antidepressants have long been used for the treatment of binge eating problems. McCann and Agras (1990) examined the effectiveness of desipramine with 23 nonpurging bulimics in a double-blind placebo-controlled trail. Subjects who received 12 weeks of antidepressants reduced the frequency of the binge eating by 63% compared to 16% for the placebo subjects. Following treatment 60% of the subjects in the desipramine condition abstained from binge eating as opposed to 15% in the placebo condition (Castonguay, Elderedge, and Agras, 1995).

Alger and colleagues (Alger, Schwalberg, Bigaouette, Michalek and Howard, 1991) used medication for treatment with obese individuals with binge eating disorder. In a double-blind placebo-controlled trial, a comparison was made between the effectiveness of 8 weeks of naltrexone or imipramine with obese binge eaters and bulimics. Relative to their respective control group neither imipramine nor naltrexone was found to significantly reduce binge frequency among obese bingers or bulimics. However, among obese bingers as compared to controls, imipramine produced a significant reduction in binge duration. Similarly, bulimics' binge duration was

significantly reduced by naltrexone. Obese bingers but not bulimics experienced a strong placebo effect (Alger, Schwalberg, Bigaoutte, Michalek, and Howard, 1991). Although the results with bulimics in this study are irregular (binge eating in bulimics usually decreased with imipramine), the results of both this study and the McCann and Agras (1990) study indicates antidepressant medication as an effective treatment among obese persons who binge (Castonguay, Elderedge, and Agras, 1995; Fairburn and Wilson, 1993).

Studies have also looked at the possible mechanism through which antidepressant medication reduces binge eating. McCann and Agras (1990) showed a significant increase in cognitive restraint (i.e., dietary awareness and conscious efforts to restrict eating) and a decrease in hunger with subjects treated with desipramine. Rossiter, Agras, Losch, and Telch (1988) found that bulimics successfully treated with imipramine maintain a highly restricted calorie intake. What is interesting about antidepressants is that they are equally effective for the binge eater, whether or not they are depressed, suggesting the action of the drug is on the brain center which controls eating (Abraham and Llewellyn-Jones, 1995).

1.2.5. CONCLUSION

To date, no model provides a clear explanation of the etiology and maintenance of binge eating and overweight within this population.

Cognitive-Behavioural Model One of the striking features of eating disorders such as bulimia and binge eating is the intensity of the patient's dysfunctional beliefs and values concerning their shape and weight. Behaviour of extreme dieting,

preoccupation with food and eating, etc, is not really surprising given the strong beliefs about weight and the need for control. Rather than being a symptom of the problem, these beliefs and values are thought to be the maintaining factor of the condition. Therefore the basic assumption of the cognitive-behavoural approach to bulimia nervosa is that concerns about weight and shape are primarily on the etiology and maintenance of a restrained eating pattern which in turn, maintains a pattern of binge eating. Thus CBT for bulimia nervosa was designed to produce such cognitive change (Fairburn, 1981, 1994). However those with binge eating disorder do not appear to follow such restrained eating patterns, so if overconcern about weight and shape do play a role in the etiology or maintenance of binge eating disorder it appears to do so largely independent of eating disorders. This is an area of research that would be of much value to the literature on binge eating.

The cognitive-behavioural model of bulimia nervosa has been important in guiding research and treatment for binge eating disorder. However elaboration is needed to accommodate differences between bulimia nervosa and binge eating disorder. For those overweight binge eaters it is important to accommodate the meaning of being overweight as it effects self-esteem and mood. "Further, a role for negative affect as a trigger of binge eating not directly linked to efforts at dieting or abstinence violation effects is warranted given the data that support this role among individuals with BED" (Castonguay, Elderedge, and Agras, 1995, p. 882-883).

Interpersonal Model IPT is equally effective as CBT at reducing binge eating, even when no attention is paid to eating behaviour. This in itself is a very telling aspect of the disorder. The theory behind IPT for binge eating disorder is that improvements in

interpersonal functioning will eliminate the problem eating behaviour. This model hypothesizes that as eating disorders appear during late adolescence when interpersonal issues are arising, binge eating is triggered by and becomes a way of coping with the negative affect common in this period. IPT is directed toward helping with the faulty interpersonal responding and the associated negative affect. There is evidence that personality disorder, especially borderline personality is common in bulimia nervosa (e.g., Cooper, Morrison, Bigman, Abramowitiz, Blunden, Nassi and Krener, 1988) and that major depression is common amongst obese patients who binge (Marcus, Wing, Ewing, Kern, Gooding, and McDermott, 1990). Interpersonal problems have shown to be common in patients with bulimia nervosa (Norman and Herzoy, 1986) and have also been implicated in its etiology (Striegel-Moore, Silberstein, and Rodin, 1986).

Such research suggests that interpersonal difficulties are important in the maintenance of binge eating and therefore therapies directed at helping with these should reduce the tendency to binge (Fairburn and Wilson, 1993). However no specific model of how interpersonal problems relate to the etiology and maintenance of either binge eating and/or obesity has been developed. IPT has had success in treatment of binge eating disorder without specifically targeting eating behaviour as such, which suggests that factors which impede interpersonal functioning, are crucial to the maintenance of the disorder (Castonguay, Elderedge, and Agras, 1995).

Biological Model More research is needed for our understanding of potential biological and physiological mechanisms involved in binge eating disorder. Although research has shown that this disorder is not a form of depression, the high rate of

affective disorder associated with it suggest that depression may influence the etiology or maintenance of binge eating disorder. Castonguay and colleagues (1995) suggest that biological factors that link depression and binge eating may be useful to our understanding of binge eating disorder.

1.3. THE RATIONNALE OF THIS RESEARCH

"Dear Mum and Dad,

I thought that I would write this letter in an attempt to try and explain what an eating disorder actually is. From talking to you about it on various occasions I have come to realize that both of you still view an eating disorder as a diet. The truth of the matter is that we focus on food and weight so that we don't have to feel any emotions or feelings that may be uncomfortable, such as anger, sadness, anxiety or guilt. We have been conditioned from childhood to suppress these feelings for various reasons, such as that it is not 'ladylike' to express them and that no one wants to be around someone who gets upset. We may have seen people become out of control with their anger and this could have scared us into believing that's what would happen to us if we became angry. The longer we suppress these feelings the more painful it becomes and thus the more we focus on our food in a desperate attempt to block them. It soon reaches a stage when all the emotions that we feel are indeed connected to our food, weight, and shape. We grow to believe that we are void of all feelings. Inside us a big hole develops and in attempt to get out of it we either try to fill it with food by bingeing or we try

to starve it away. However this hole is bottomless and will not disappear....

Because we have blocked our emotions for so long, once we begin to eat 'regularly' and shift the focus from food, sometimes the pain that we have to feel is too much for us. It is only when you are ready, that you can work through all the emotions that have been building up inside of you over the years that the eating disorder has been around. Obviously the more years that the eating disorder has been there the more feelings there are to get through..." (Abraham and Llewellyn-Jones, 1995, p. 37-38).

1.3.1. THE ROLE OF EMOTIONS IN BINGE EATING

In most cultures we are socialized to love food. Rich sweet foods are linked with love, nurturance and warmth; emotional nourishment is connected with physical nourishment. Even the words we use to express love, are food words, such as sweetie, sugar and honey. The emotional power of food is matched by a chemical power that in some sense is addictive. For example, Christmas dinner has the sedating effect that makes us feel sleepy and mildly euphoric. Sugary foods are used by many women to medicate pain and anxiety. Food becomes used as a drug to medicate emotional pain (Pipher, 1994).

A female stereotype exists in our society which includes aspects of warmth and expressiveness (Broverman, Vogel, Broverman, Clarkson, and Rosen-krantz, 1972); passivity and weakness (Best, Williams and Briggs, 1980); in terms of behaviour roles of wife, mother and homemaker; in terms of appearance a slim outward physique. There is a continuum as to whether women adhere to the female sex-stereotype. Some do this strongly and they are referred to as sex-typed, some do a little, some not at all. In women, a positive relationship has been repeatedly found between the degree of sex-typing in terms of personal attributes and increased emotionality (e.g. Berm, 1975; Kelly and Worrell, 1977; Taylor and Hall, 1982), which could be due to a lack of assertiveness and adaptive behaviours connected with female stereotype traits. Lack of assertiveness and adaptive coping behaviours are likely to create a negative self-concept, anxiety and a tendency to worry, as the individual experiences powerlessness and helplessness in their life. Believing that action is useless, negative emotions in particular are suppressed in the form of body language. The theory of learned helplessness (Seligman, 1975) views depression as an organismic response to suppressed hostility and aggression. Similarly, under or overeating may be an organismic response to perceiving one has no control over events, given specific learning experience regarding food (Van Strien, 1991).

Support for the hypothesis that overeating is related to the degree of sex-typing was found in a study of 450 women, where emotional eating appeared to be related to adherence to feminine stereotype traits, not to adherence to masculine stereotype traits (Van Strien and Bergers, 1988).

There is much research (Bruch, 1969; Heatherton, 1991) that suggests that binge eating episodes are preceded by some form of emotional distress. The most frequently cited trigger of a binge episode is stress or negative affect (Abraham and Beumont, 1982; Baucon and Aiken, 1981; Elmore and De Castro, 1990; Bruch, 1969; Heatherton, 1991). Crowther, Lingseiler, and Stephens (1984), found that binge eaters compared to non-binge eaters, more frequently reported negative moods while eating and these feelings were most often associated with binge eating episode. Studies showed experimentally induced dsyphoria causes restrained eaters or dieters (Heatherton, Herman, and Polivy, 1991; Herman and Polivy, 1980) to eat more than unrestrained or nondieters. Bulimia nervosa patients also frequently report (Abraham and Beumont, 1982; Elmore and De Castro, 1990; Johnson and Larson, 1982) that their binges are triggered by some sort of emotional distress (Hawkins Fremouw and Clement, 1984).

There is also much research suggesting that those who binge tend to have limited ability in recognizing and coping with emotions. This leaves them with a variety of emotional deficits and problems. Such deficits are especially noticeable when they attempt to express anger, frustration, disappointment, sadness, boredom and other uncomfortable feeling states. Some binge eaters do not make distinctions between negative feelings and hunger and often eat in response to any emotional distress. Bruch (1969) hypothesized that the inability to recognize and respond appropriately to one's bodily urges is fundamental in the etiology of eating disorders. Other binge eaters are scared of losing control emotionally and so, in order to avoid negative emotion, stuff down their feelings with food. In some cases, binge eating serves as a temporary diversion from experiencing negative feelings. Instead of crying, they

binge. In such cases, binge eating serves the purpose of an emotional release mechanism (Hawkins, Fremouw and Clement, 1984).

1.3.2. THEORIES ON OVEREATING AND EMOTIONS

In presenting the following three theories it must be pointed out that they have not been developed for the purpose of understanding binge eating disorder, but in relation to overeating.

Psychosomatic theory According to psychosomatic theory, overeating is a result of confusion between physiological states that accompany negative emotions. Those individuals who often turn to emotional eating are thought to be less adjusted, to display distinct personality traits and to have a characteristic emotionality. Bruch conceptualizes emotional eating begins in early infancy as a result of repetitive inappropriate responses of the mother to the child. The mother pays little attention to the child except to stuff it with food. As an adult the child will be unable to recognize whether it is hungry or not, or whether it is suffering from some other discomfort, and therefore may overeat in response to practically any arousal state. The individual suffers from a lack of awareness (Bruch, 1961). In addition, outcome may be a deficient inner cognitive and affective structure, which may be partnered with difficulties in labeling emotional states. Negative emotions may especially be experienced as diffused states (Van Strien, 1991).

Externality theory Externality theory also assumes overeaters have lost contact with feelings of hunger and satiety, but this is due to a general sensitivity to external cues

such as sight and smell of food. The external theory refers to 'external eating', a heightened sensitivity to food cues, and these individuals are characterized as 'stimulus bound' (Schachter and Gross 1968).

Emotional and external eating are not all that dissimilar. The externality theory assumes a close link between emotionality and externality as a high degree of emotionality, characteristic of many external eaters, is viewed as one of the aspects of externality as a personality trait (e.g., Schachter and Rodin, 1974). In addition, various experiments by Slochower (1983) have shown uncontrollable anxiety to enhance an overweight person's reactivity to external cues. Thus psychosomatic and externality theory can be combined as both anxiety and food cues need to be present in order for the individual to overeat (Van Strien, 1991).

Restrained Theory Herman and Polivy (Herman and Polivy, 1980; Polivy and Herman, 1983), give a totally different point of view on emotional eating in their theory of restrained eating. The theory attributes overeating to dieting. Dieting, in turn, requires conscious cognitive monitoring, selection, and rejection of food, and of opportunity to eat. Reducing body weight through restriction of food intake triggers defenses such as reduction of the metabolic rate and arousal of persistent hunger. Negative emotions reduce the value of being slim or in good health and the desire to eat overrides the cognitive restraint dieters usually demonstrate and excessive intake of food may occur. Thus emotional eating occurs when the cognitive resolution not to eat is abandoned.

Although the three theories differ in their assumption as to why emotional eating occurs, all concur that emotional eaters have a heightened level of emotionality and that emotional eaters have difficulty in correctly perceiving or responding to feelings of hunger and satiety.

Such evidence supports the idea of a treatment program that teaches emotional discrimination and management. According to some writers (Goleman, 1995; Salovey and Mayor, 1989-1990), such skills would be termed as "emotional intelligence". It is a term that stirred controversy four years ago with the release of *"Emotional Intelligence: Why it Can Matter More Than IQ"* by psychologist Daniel Goldman, Ph.D. According to Salovey, emotional intelligence includes the following five domains. 1) Knowing one's emotions. Self-awareness – recognizing a feeling as it happens. This is the root of emotional intelligence. To be capable of monitoring feelings from moment to moment is critical to psychological insight and self-understanding. Being incapable of noticing our true feelings makes us powerless. Those with greater certainty about their feelings better direct their lives and have a greater sense of who they are and how they feel about decisions that they make from whom to marry to what job to take. 2) Managing emotions: Managing feelings so they are appropriate is a skill that builds on self-awareness. People who lack this ability are continually fighting feelings of distress, while those who are skilled in it bounce back more quickly from life's upsets. 3) Motivating oneself: Marshalling emotions to help reach goals is essential for paying attention, self-motivation and creativity. Emotional self-control, delaying gratification, and stifling impulsiveness is the basis of any kind of accomplishment. This skill tends to make a person more highly productive and effective in the things that they do. 4) Recognizing emotions in

others: Empathy is the fundamental 'people' skill. People who are empathic are more aware of social signals indicating what others need or want. 5) Handling relationships: This skill, for the most part, is managing emotions in others. Social competencies are what produce popularity, leadership and interpersonal effectiveness. Those who excel in social competencies do well at anything that relies on interacting smoothly with others (Goleman, 1995).

This programme concentrates on two aspects of "emotional intelligence". Knowing one's emotions, and managing one's emotions.

1.4. THE PROGRAMME

1.4.1. MONITORING

Throughout the six weeks, participants are required to monitor their food and emotions every day on monitoring forms. Self-monitoring records specify the following information; the time of consumption; the location; the social, emotional, and environmental context; the type and amount of food or liquid consumed; indication as to binges/excessive eating; the emotion that they are feeling. See appendix page 93 for an example monitoring sheet.

The purpose of self-monitoring is twofold: first it provides a detailed picture of how the participants eat, thereby bringing to their attention the exact nature of their eating problem; and second, by making them more aware of what they are dong at the very time that they are doing it, self-monitoring helps change behaviour that previously seemed automatic and uncontrollable (Fairburn, Wilson and Marcus, 1993). Affective experiences are also required before and during eating. "Recognition of insight into the events precipitating these negative mood states in conjunction with more structured interventions to effectively deal with precipitation events may be another treatment alternative" (Crowther, Lingswler, and Stephens, 1984, p. 303).

Many individuals find keeping a record helpful for establishing an appropriate eating routine, as well as the associated feelings and circumstances. Daily diaries have become popular (Fairburn, 1982; Lacey, 1983; Long and Cordle, 1982; Loro and Orleans, 1981, Mitchell, Pyle, and Eckert, 1981; Mizes and Lohr, 1983; Welch, 1979). In the short term self-monitoring has shown to lead to reductions in frequency

of bingeing and vomiting with bulimics. Those who monitored prior to treatment experienced a 25-30% decrease in symptoms (Johnson, Connors and Stuckey, 1983). The monitoring sheets will not be used as data source but will be used with the intention of benefiting the participants.

1.4.2. EMOTIONS

The programme spends much time looking at emotions, their importance, their role, and how to better identify them (see appendix p.83). Managing emotions comes in the form of four techniques: relaxation, problem solving, emotional regulation writing task, and assertion training.

1.4.3. RELAXATION

Relaxation training has been successfully employed in clinical practice for a variety of behavioural and physical problems (Jacobson, 1938; Schultz and Luthe, 1959). Sherman and Plummer (1973) show that relaxation may be useful as a self-management skill for controlling tension and reducing dysphoric affect in specific stressful situations. As many binge eaters experience anxiety before a binge, it makes sense to introduce relaxation as an emotional management technique. Relaxation is very easy to teach and people find it enjoyable and helpful.

1.4.4. PROBLEM-SOLVING SKILLS

Although the immediate antecedent to a binge is usually a negative emotion this is often provoked by an external problem. Research indicates eating disordered individuals have poor problem-solving abilities (Streigel-Moore, Silberstein, and Rodin, 1986). Specifically, several authors have suggested that a deficit in coping

skills or general problem-solving inadequacies may make eating disordered individuals less effective in dealing with stress and the eating disorder could be a manifestation of maladaptive coping styles (Caffary, 1987; Hawkins Fremouw and Clement, 1984). Soukup and colleagues (1990) found that both bulimic and anorexic individuals had poorer coping skills than individuals without eating disorders, and in addition, the way in which they did cope with stress was dysfunctional, e.g., avoiding confronting their difficulties.

By developing problem solving skills to help cope more effectively with such problems, this will help reduce an individuals' vulnerabilities to binge. Difficulties once unaddressed are now faced. Problem solving has been used in previous treatment for eating disorders such as in Fairburn, Marcus and Wilson's (1993) Cognitive Behavioural Therapy for Binge Eating and Bulimia Nervosa.

1.4.5. SELF-REGULATION WRITING TASK

More and more evidence is showing that disclosure of stressful experiences through writing can provide therapeutic benefits for a large number of people. Research has found that writing about traumatic experiences produces improvements in immune function, reductions in physician visits for illness, and better performance at school and work (Pennebaker 1993; Spera, Burfeind, and Pennebaker, 1994). Other studies suggest that failure to talk or acknowledge significant experiences is associated with increased health problems, autonomic activity and rumination (e.g., Rime, Mesquita, Philippot, and Boca, 1991). The connections between disclosure and health have now been firmly established.

When a person talks or writes about an emotional event, important biological changes occur. Talking about trauma brings about reductions in blood pressure, muscle tension and skin conductance during or immediately after disclosure. Studies indicate however, that long-term health benefits of disclosure are only apparent if the individual is encouraged to write about or express their emotions as opposed to providing factual accounts of their upheaval (Pennebaker, 1995).

It is felt that translating experiences into words forces some kind of structure to the experiences themselves. Through language, one can organize, structure, and ultimately assimilate both emotional experiences and the events that may have provoked the emotions. Talking about an event can accomplish two important goals. Firstly, talking reflects and reduces anxiety. Secondly, repeated disclosure over time gradually assimilates the upsetting experience (Pennebaker, 1989).

The main value of disclosure writing is that an emotional reversal process can be attained within a short time. This emotional reversal occurs "when healthy and chronic pain patients attain insight from expressing and becoming aware of their deepest emotional secrets or pains and their related thoughts and psychological patterns of response" (Pennebaker, 1989, p. 269). Verbal reports after writing sessions report that a writing interaction produces the fastest transition from one emotional state to another than any other psychological techniques employed (Pennebaker, 1989).

A self-regulation-writing task as opposed to disclosure writing is a little more specific. Research by Cameron and Nicholls (1998) showed that optimists reduced illness-

related clinic visits during the following month using self-regulation task and disclosure task. However, among pessimists, only the self-regulation task was successful in reducing clinic visits. As it is a more focused task it was felt self-regulation would be more beneficial than disclosure for binge eaters. The task not only allows a person to explore their thoughts and feelings about stressful experiences, but helps focus on selecting, enacting and appraising specific ways to cope with their problems (Cameron and Nicholls, 1998). By being able to express their feelings safely and to come up with some coping strategies this is a third emotional management technique included in the programme.

1.4.6. ASSERTION TRAINING

Assertion training is the teaching of social interaction skills which are direct and straightforward, but which also respect the feelings of others (Rimm and Masters, 1979). Binge eaters tend to take poor care of themselves physically and emotionally yet overextend themselves to help others. They give up rest and relaxation to accomplish unreasonable expectations or unrealistic goals. Taking on more responsibility and tasks than they realistically can complete they usually end up disappointed and dissatisfied. Such experiences result in a recurrent feeling of being depleted or burned out, making binge eating a futile attempt to restock depleted emotional stores (Hawkins, Fremouw and Clement, 1984).

"I'm constantly trying to please people and to do what I believe they expect of me and I have stopped being myself because of it. Always being ready to listen to and help others. Always being selfless is

partly a cause of this problem" (Abraham and Llewellyn-Jones, 1995, p. 135).

Assertiveness training is often a component of stress management programs for the following reasons. First, behaving in an assertive way results in an increased feeling of well-being for the individual. It is felt that assertive behaviour is incompatible with anxiety. Second, assertive behaviour is helpful for stress as it has the potential to increase an individual's control over her environment. Thirdly, behaving in an assertive manner requires the person to become aware of and accept a variety of personal rights (Cotton, 1990).

Research has shown that eating disorder subjects display a lack of self-assertion compared to both dieting and normal control groups (Williams, 1985; Williams, Chamove, and Millar, 1990). Therefore assertion training is a fourth emotion management technique, teaching some basic assertion skills such as how to say 'no' to unreasonable requests and the belief that their feelings are as important as those of anyone else.

CHAPTER 2: METHOD

2.1. PARTICIPANTS

Forty-six women were recruited from advertisements posted around the University of Canterbury and the Christchurch College of Education. (see appendix p. 151 for advertisement). They were initially invited to take part in some research on eating and emotions by completing two questionnaires, the Eating Disorder Inventory-2 and the Middlesex Hospital Questionnaire. Those that showed no evidence of binge eating were eliminated. Of the 18 remaining, 5 were eliminated for various reasons, and 3 did not want to participate in the programme. Of the remaining 10, 3 completed the programme in full while 3 were used as a control group. Participants were unable to be allocated to the two groups through quasi-random allocation, as it was simply a matter of who could participate at the particular time the programme was being run.

2.2. PROCEDURE

The programme involved a psychoeducational approach teaching emotional discrimination and management. The programme was made up of eight sessions that ran over six weeks. See appendix p.83 for the programme manual.

The participants in both the programme and control group filled out, in addition to the EDI-2 and Middlesex Hospital Questionnaire, the Beck Depression Inventory, the Beck Anxiety Inventory, the COPE, the General Health Questionnaire, and the Emotional Eating Scale. These were then readministered once the programme was complete and again at one month follow-up.

2.3. MEASUREMENTS

2.3.1. EATING DISORDER INVENTORY-2 (EDI-2)

The eating Disorder Inventory-2 (EDI-2; Garner, 1991) is a standard self-report measure for the assessment of anorexia nervosa (AN) and bulimia (BN). It was revised from the Eating Disorder Inventory (EDI; Garner and Olmstead, 1984) to form a set-point response continua of "Always", "Usually", "Often", "Sometimes", "Rarely", and "Never". Items scores range from 0-3, with some items being reverse-scored.

The EDI-2 is made up of eleven scales. Drive for thinness (DT) (7 items, possible score 0-21), bulimia (B) (7 items, possible score 0-21), and body dissatisfaction (BD) (9 items, possible score, 0-27), which are directly related to attitudes towards eating and bodyweight. Ineffectiveness (I) (10 items, possible score, 0-30), perfectionism (P) (6 items, possible score, 0-18), interpersonal distrust (ID) (7 items, possible score 0-21), interoceptive awareness (IA) (10 items, possible score 0-30), and maturity fears (MF), (8 items, possible score, 0-24) which are not directly related to food and weight (Garner, Olmsted, and Polivy, 1983). Asceticism (A) (8 items, possible score 0-24), designed to measure control over one's own behaviour through self-denial, self-restraint, and self-discipline in order to obtain rigid spiritual ideals. Impulse regulation (IR) (11 items, possible score 0-33) designed as a measure of one's propensity toward impulsive acts such as substance abuse and self-destruction. Social insecurity (SI) (8 items, possible score 0-24), designed to measure perceptions of social relationships as being tense, unfulfilling and pervaded by a general expectancy of disappointment.

The internal consistency and factor structure of the original 64 items have been well established (Ebernez and Gleaves, 1993; Garner, 1991; Welch, Hall and Norring, 1990). However there are mixed results with the additional 27 items (Ebernenz and Gleaves, 1993; Garner, 1991).

This questionnaire was used to assess the participant's binge-type behaviours through the use of the Bulimia scale. It was also used to screen out participants showing symptoms of anorexia, and possible commorbid problems such as borderline personality disorder (BPP) (hence the use of the additional 27-item scale). IR items refer to traits similar to those associated with BPD).

Although this questionnaire can not be used as a diagnostic instrument for binge eating, I was more interested in general binge eating behaviour as opposed to DSM-IV clinical diagnosis. Questions such as "I eat when I am upset", "When I am upset, I worry that I will start eating", "I have gone on eating binges where I felt I could not stop", were of particular interest to me. In addition to providing an indication of the likelihood that a respondent may be suffering from binge eating disorder, the questionnaire can give us so much information in one. Therefore it was decided that this was the most appropriate eating disorder inventory to use.

2.3.2. MIDDLESEX HOSPITAL QUESTIONNAIRE (MHQ)

The Middlesex Hospital Questionnaire (MHQ) first described in 1966 by Crown and Crisp (Crown and Crisp, 1966, 1970), is a brief 48-item self-rating inventory designed

to measure aspects of six distinct categories of psychoneurosis and affective status. Anxiety, Phobia, Obsessonality, Somatic, Depression, and Hysteria.

Research has found the MHQ to be a reliable instrument (Crisp, Jones and Slater, 1978; Bagley, 1980; Crisp, Ralph, McGuiness and Harris, 1978). Mauissakalian and Michelson's (1981) study found the MHQ significantly differentiated between diagnostic groups. In addition 75% of the patients could be correctly classified as either having a neurosis or personality disorder by their MHQ scores. The questionnaire was used in the study to assess for any commordid disorders in the participants, and to screen out any participants showing severe problems. A clinical psychologist assisted with the interpretation of the scores, and screening for co-morbid disorders.

2.3.3. BECK DEPRESSION INVENTORY (BDI)

The Beck Depression Inventory (Beck, Ward, Mendelson, Mock, and Erbaugh, 1961) is a self-report instrument designed to measure depressive symptomatology. The BDI contains 21 items that are made up of groups of four statements. The participants must choose the one that best represents their feelings at the time. Each of the four statements has a four-point continua from 0-3. The higher their score, the higher the level of depression is considered to be. The summed item scores (0-63) can then be categorised in terms of severity of depression: 0-9 is normal range, 10-19 mild-to-moderate depression, 20-29 moderate-severe depression, and, 30-36 severe depression.

The validity and reliability of the BDI has been established (Carson, 1987; Beck, Steer, and Garbin, 1988; Beck, 1970). Because co-occurrences of eating disorders and depression are frequent making diagnosis difficult, research has been done to investigate whether the factor structure of the BDI was consistent with a measure of depression in individuals with eating disorders (Pulos, 1996). The BDI was shown to be an adequate measure of depression in those with an eating disorder. In addition, because the BDI has been used in much of the research on eating disorders, comparisons can be made across other studies.

As the study was looking at improving emotional management and negative mood in particular, it is felt looking at depression is very valid for this study. The BDI was also considered important in this research as it was considered that giving binge eaters better coping strategies for depression would help their eating disorder.

2.3.4. BECK ANXIETY INVENTORY (BAI)

The Beck Anxiety Inventory (Beck, Epstein, Brown, and Steer, 1988) is a self-report instrument designed to measure anxiety. The BAI asks participants to respond to the extent to which they were bothered by each item during the past, including today on 21 anxiety symptom items. Responses in the form of, not at all (0), mildly (1), moderately (2), severely (3) – are scored on a 0-3 scale.

The BAI has shown to have good psychometric properties, with a high level of internal consistency (Creamer, Foran, and Bell, 1995; Beck, Epstein, Brown, and Steer, 1988). However its high level of discriminative validity may be at the expense of some construct validity (Creamer, Foran, and Bell, 1995).

As binge eating episodes are shown to be preceded by stress and anxiety and the BAI is a psychometric measure of these emotional states, it was also selected for study.

2.3.6. THE EMOTIONAL EATING SCALE (EES)

The Emotional Eating Scale (EES) was designed (Arnow, Kenardy, and Agras, 1994) to facilitate investigation of the relationship between specific negative emotional states and overeating. It is a 25-item scale in a Likert-type format for assessing the urge to cope with negative affect by eating. The five-point scale is anchored on "no desire to eat", "a small desire to eat", "a moderate desire to eat" and "an overwhelming urge to eat" at the immediate points. It has three separate subscales, anger/frustration, anxiety, and depression (Arnow, Kenardy and Agras, 1995).

Results indicate internal consistency and adequate temporal stability (Arnow, Kenardy, Agras, 1995; Tanofsky, Wifley, Spurrel, Welch and Brownell, 1997).

Treatment associated changes in binge eating have been shown to be associated with changes in the EES subscales (Arnow, Kenardy and Agras, 1995).

2.3.6. COPE

The COPE (Carver, Scheiver, and Weintraub, 1989) is a multidimensional coping inventory. It includes 13 conceptually distinct scales used to assess situational coping (responses to a specific situation or during a specific periods) or dispositional coping (typical responses to stresses), or both. The COPE is made up of the following scales: 1. Active coping; taking action and exerting efforts to remove or circumvent the stressor. 2. Planning; thinking about how to comfort the stressor, planning one's

active coping efforts. 3. Seeking instrumental social support; seeking assistance, information or advice about what to do. 4. Seeking emotional social support; getting sympathy or emotional support from someone. 5. Suppression of competing activities; suppressing one's attention to other activities in which one might engage in order to concentrate more completely on dealing with the stressor. 6. Turning to religion; increased engagement in religious activities. 7. Positive reinterpretation and growth; making the best of the situation by growing from it, or viewing it in a more favorable light. 8. Restraint coping; coping passively by holding back one's coping attempts until they can be used. 9. Acceptance; accepting the fact that the stressful event has occurred and is real. 10. Focus on and venting of emotions; an increased awareness of ones' emotional distress, and a concomitant tendency to discharge those feelings. 11. Denial; an attempt to reject the reality of the stressful event. 12. Mental disengagement; psychological disengagement from the goal with which the stressor is interfering, through day-dreaming, sleep or self-distraction. 13. Behavioural disengagement; giving up, or withdrawing from the attempt to attain the goal with which the stressor is interfering. Two additional scales, alcohol/drug use, and humour were developed later and have been added since, but these are still regarded as more exploratory. The scores for each type of coping is used to enable us to see which coping strategies are used more frequently (Weimann, Wright and Johnson, 1995).

Scales 1, 2, 3, 7, 9 measuring coping response; active coping, planning, seeking instrumental social support, positive reinterpretation and growth, and acceptance, are thought to be adaptive in situations where active coping is associated with a good outcome. With scales 4, 5, 8 seeking emotional social support, suppression of competing activities, and restraint coping, there is a less obvious link with active

coping but these should also be adaptive. In contrast, scales, 10, 11 and 13 focus on venting emotions, denial, and behavioural disengagement, and are expected to be maladaptive where active coping is called for, but they are not intrinsically maladaptive since there may well be health related situations where they are particularly valuable (Weimann, Wright and Johnson, 1995).

Carver, Scheiver, and Weintraub, (1989) found that the internal consistency of the COPE scales were acceptably high, and that the coping tendencies measured by the COPE are reasonably stable.

Research has also supported the idea that those with eating disorders have poor coping skills (Heilbrun and Harris, 1986). As binge eaters do not have the skills to cope with negative situations appropriately, and the programme was intended to enhance these skills, the COPE was chosen as a measure of this aspect.

2.3.7. THE GENERAL HEALTH QUESTIONNIAIRE (GHQ)

The General Health Questionnaire (Goldberg, 1972) can serve as a screening instrument in community surveys and identify 'potential cases', leaving the task of identifying 'actual cases' to psychiatric interviews (Goldberg, 1972).

There are 60 items consisting of a question asking whether the respondent has recently experienced a particular symptom or item of behaviour on a scale consisting of 'less so than usual' 'no more than usual', and 'much more than usual" (Goldberg, 1972).

It may be scored in two ways. It can be treated as a Likert scale where weights are assigned to each position, e.g., 1, 2, 3, 4. Or it can be treated as a bimodal response scale so only pathological deviations from normal signal possession of the item, e.g., 0, 0, 1, 1. This method of scoring has the advantage that it eliminates any errors due to 'end users' and 'middle-users' (Goldberg, 1972). Validity of the questionnaire has been established (Goldberg, 1972).

The GHQ was used to assess the general health of the participants and to compare their scores before and after treatment.

CHAPTER 3: RESULTS

Examining the effectiveness of the programme has proven to be very difficult due to problems recruiting participants. With such a small sample, statistical tests have not been used. Therefore only descriptive statistics will be shown. Any generalizations made from the results, are done so with caution.

The Middlesex Questionnaire will not be shown in this section as it was simply used to check for any serious psychopathology on selection of the participants. However results can be seen in the appendix p. 153.

3.1. DEMOGRAPHIC DATA

Table 2. Participants' age ethnicity and weight category.

	Programme group	**Control Group**
Age	25, 26, 32	24, 27, 47
Ethnicity	2 Pakeha, 1 Maori	3 Pakeha
Weight category*	normal (on diet), overweight, gross obesity	Normal (on diet), 2 obese

The weight categories shown above are not surprising given that most patient currently presenting for treatment for binge eating disorder are overweight.

* Weight categories were calculated according to the Body Mass Index (BMI), which uses the simple formula weight in kilograms divided by height in meters times height in meters. Normal range of weight is 19-24.9. Overweight is 25-29.9. Obesity is 30-39.9. Severe or morbid obesity is 40-or more.

Table 3. EDI-2 means, standard deviation, and ranges of the combined participants scores, separate scores of the programme and control group before and after the programme and at follow-up, and samples of anorexic, bulimic and healthy women's scores as a comparison.

Variable Treated	Anorexic* (N=25)	Bulimic* (N=32)	Healthy* (N=25)	Participants (N=6)	Programme (N=3)			Control (N=3)		
					Before	After	Follow-up	Before	After	Follow-up
Drive for Thinness	14.9 (5.4) [1-21]	15.1 (5.7) [1-21]	4.3 (3.8) [0-11]	8 (6.3) [0-18]	10 (7.2) [4,8,18]	11.3 (7.7) [5,9,20]	9.3 (9.3) [3,5,20]	6 (6) [0,6,12]	7.3 (5.8) [4,4,14]	6.7 (8.1) [1,3,16]
Bulimia	4 (5.9) [0-21]	8.8 (5.7) [1-20]	1 (1.5) [0-6]	6.7 (2.3) [4-10]	8.7 (1.2) [8,8,10]	6.7 (5.5) [3,4,13]	5.7 (5.5) [0,6,11]	4.6 (0.6) [4,5,5]	5 (1.7) [3,6,6]	6.3 (5) [1,7,11]
Body Dissatisfaction	19 (6.5) [3-27]	21 (4.2) [13-27]	11.5 (8.7) [0-25]	18.5 (4.3) [13-25]	20.6 (4.5) [16,21,25]	18.3 (8.1) [11,17,27]	17.7 (4.9) [12,20,21]	16.3 (3.5) [13,16,20]	14 (3) [11,14,17]	14.3 (4.5) [10,14,19]
Ineffectiveness	15.8 (8) [2-30]	12.2 (5.1) [2-21]	1.9 (3.2) [0-12]	7.7 (5.6) [0-17]	6.3 (1.2) [5,7,7]	3.3 (3.5) [0,3,7]	1.7 (4.9) [0,0,5]	9 (8.5) [0,10.17]	6.7 (5.8) [0,10,10]	6 (4.5) [2,5,11]
Perfectionism	10.6 (4.2) [4-18]	8 (4.5) [1-18]	3.9 (3.7) [0-12]	7.1 (6.1) [1-16]	10 (7.2) [2,12,16]	8.6 (7.5) [0,13,13]	7.7 (6.1) [1,9,13]	4.3 (4.2) [1,3,9]	5 (4.3) [2,3,10]	4.7 (4.5) [0,5,9]
Interpersonal Distrust	7.9 (4) [1-17]	7.4 (3.8) [0-14]	2.3 (3.4) [0-13[	3.2 (4.7) [0-12]	1.6 (2.9) [0,0,5]	0.7 (1.6) [0,1,1]	1 (1) [0,1,2,]	4.7 (6.4) [0,2.12]	5.7 (7.2) [1,2,14]	5.7 (7.2) [1,2,14]

Table 3 continued

Variable Treated	Anorexic (N=25)	Bulimic (N=32)	Healthy (N=25)	Participants (N=6)	Programme (N=3)			Control (N=3)		
					Before	After	Follow-up	Before	After	Follow-up
Interoceptive Awareness	14 (7.6) [0-29]	12.2 (5.9) [1-29]	3.2 (3.4) [0-12]	3.2 (4.7) [5-9]	7.3 (2.1) [5,8,9]	6 (2.6) [3,7,8]	4 (2.6) [2,3,7]	6 (1) [5,6,7]	5.7 (4) [1,7,9]	10.3 (5.5) [5,10,16]
Maturity Fears	6.6 (5.9) [0-21]	4.8 (3.9) [0-15]	2.7 (2.6) [0-12]	2 (2.5) [0-7]	1.3 (2.3) [0,0,4]	3.3 (1.5) [2,3,5]	2 (1) [1,2,3]	2.6 (3) [0,2,6]	1 (1.7) [0,0,3]	0 (0) [0,0,0]
Asceticism	11.2 (5.3) [3-21]	9.8 (5.6) [2-21	3.1 (2.1) [0-8]	7.2 (4.7) [0-13]	8 (7) [0,11,13]	4 (5.2) [1,1,10]	5 (6) [1,2,12]	6.3 (2) [4,7,8]	6.3 (3) [3,7,9]	6.7 5 [2,6,12]
Impulse Regulation	8.1 (6) [0-20]	7.1 (4.4) [0-18]	3.1 (3.2) [0-13]	3.7 (4.4) [0-12]	2.3 (2) [0,3,4]	3 (2.6) [0,4,5]	1.3 (1.1) [0,2,2]	5 (6.2) [0,3,12]	8 (5.6) [3,7,15]	6.7 (3.2) [3,8,9]
Social Insecurity	11.1 (3.5) [1-16]	9.5 (3.4) [2-17]	3.7 (2.6) [0-11]	5.5 (5) [0-13]	4 (3.6) [1,3,8]	4.7 (3.2) [1,6,7]	4 (3) [1,4,7]	7 (6.6) [0,8,13]	7.7 (7) [0,9,14]	6 (6.2) [1,4,13]

Values shown as means, standard deviations in parenthesis ( ), range is parentheses [ ].

* Data of anorexic, bulimic and healthy group samples taken from Archer (1996).

3.2. EATING DISORDER INVENTORY-2

Table 3 presents mean values, standard deviations and ranges for EDI-2 subcategories for the combined participants scores, the separate scores for the programme and control group before and after the programme and at follow-up, plus a sample of anorexic bulimic and healthy women's scores as a comparison (from Archer, 1996).

As can be seen in Table 3, the scores on the EDI-2 for participants in this programme are not as high as the anorexic and bulimic scores. This is not surprising given that psychopathology is generally worse within anorexic and bulimic groups than it is within binge eating disorder individuals. The participants in this programme show higher scores than the healthy sample, and although at follow-up the programme participants are showing a decreasing trend, they, along with the control group are not within the healthy range at follow-up.

3.2.1. INDIVIDUAL EDI-2 SCORES

Given the focus of this research, the bulimic subcategory is of particular interest. Figure 2.1. shows participant 1's results on the EDI –2 at three points in time. On the bulimic scale, participant 1 dropped from an 8 before the programme to a 3 at its completion. At follow-up however, participant 1 scored 6 on the bulimic subcategory. Ineffectiveness had a noticeable drop from 5 to 0. Overall, 7 of the categories were down at follow-up.

Figure 2.2. shows participant 2's results on the EDI-2 at three points in time. Participant 2 showed no reduction on the bulimic subcategory at 10 before the programme, 13 at the completion of the programme, and 11 at follow-up. Participant 2 did show a noticeable drop in the ineffectiveness category from 7 before treatment to 0 at follow-up.

Figure 2.3 shows programme participant 3's results on the EDI-2 at three points in time. On the bulimic scale participant 3 dropped from an 8 before the programme to a 4 at the completion on the programme and, at one month follow-up, to 0. Perfectionism also dropped noticeably from 16 before the programme to 9 at completion. Overall 7 of the 11 subcategories were down at follow-up.

Figure 2.4. shows control group participant 1's results on the EDI-2 at three points in time. Participant 1 showed a decrease over the three time frames on her bulimic subcategory from 4 to 3, to 1 at follow up. Participant 1 also had a noticeable drop on her ineffectiveness subcategory decreasing from 17 at the first time frame to 5 at follow-up.

Figure 2.5. shows control group participant 2's results on the EDI-2 at three points in time. Participant 2 showed an increase in her score on the bulimic category, increasing from a 5 at the first time frame to 7 at follow-up. Excluding perfectionism, interpersonal distrust and maturity fears, which remained the same, all the subcategories were higher at follow-up than they had been at the first time frame.

Figure 2.6. shows control group participant 3's results on the EDI-2 at three points in time. Participant 3 showed an increase in her score on the bulimic category,

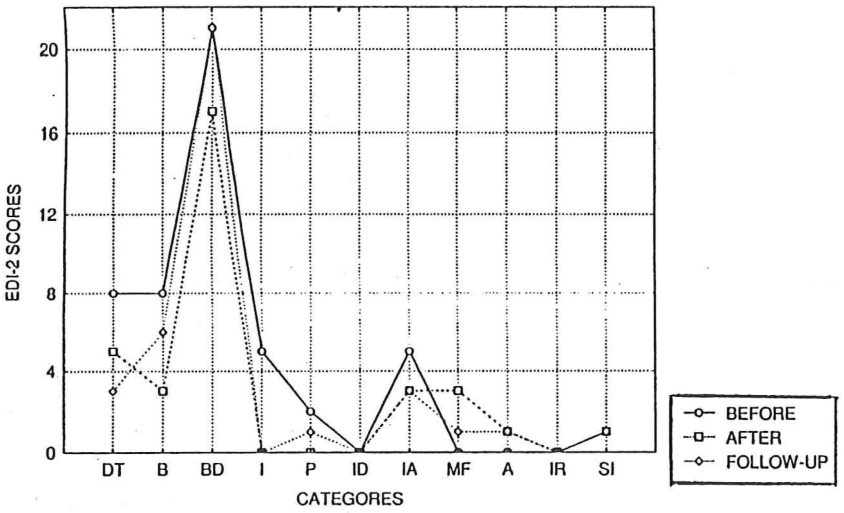

Figure 2.1. EDI-2 Scores For Programme Participant 1 Before and After the Programme and at 1-Month Follow-up.

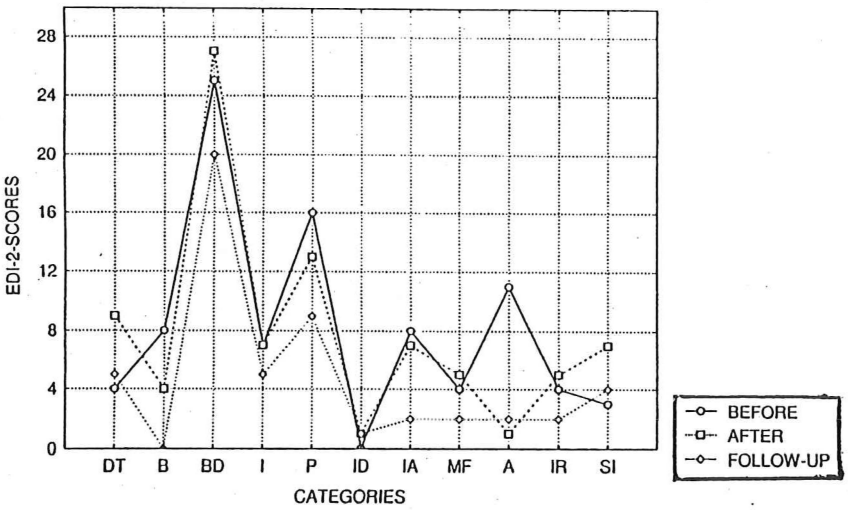

Figure 2.2. EDI-2 Scores For Programme Participant 2 Before and After the Programme and at 1-Month Follow-up.

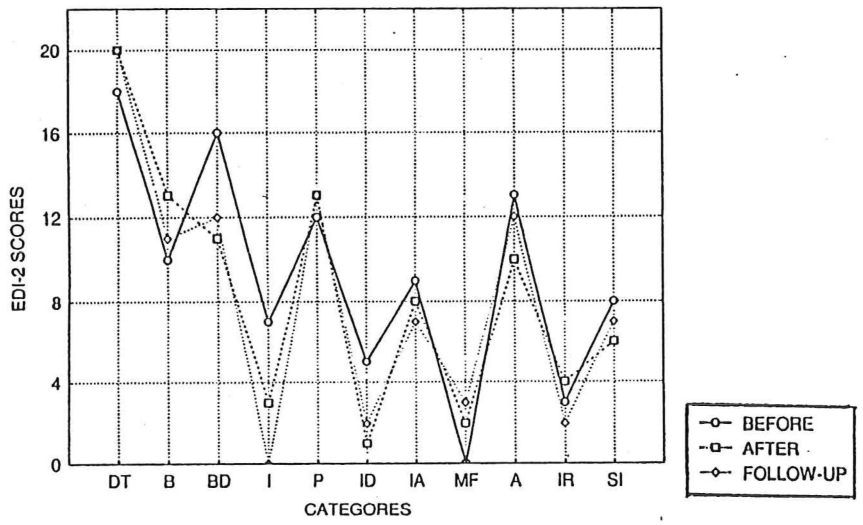

Figure 2.3. EDI-2 Scores for Programme Participant 3 Before and After the Programme and at 1-Month Follow-up.

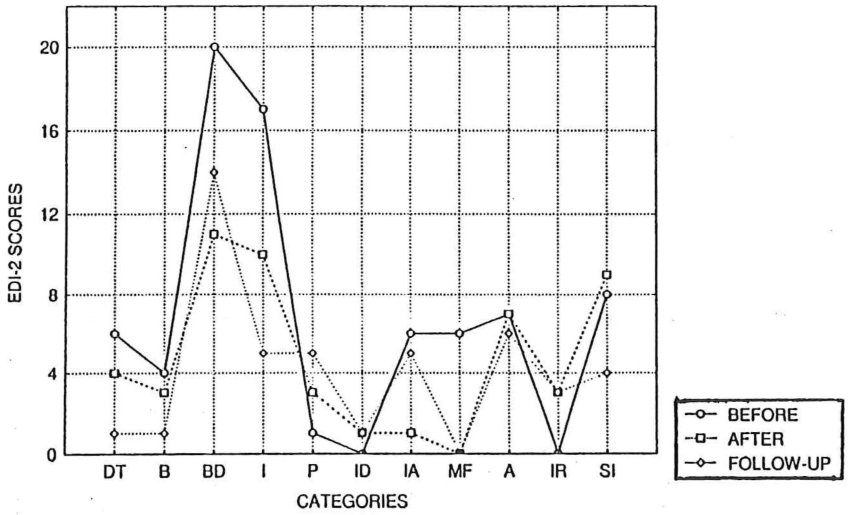

Figure 2.4. EDI-2 Scores For Control Group Participant 1 Before and After the Programme and at 1-Month Follow-up.

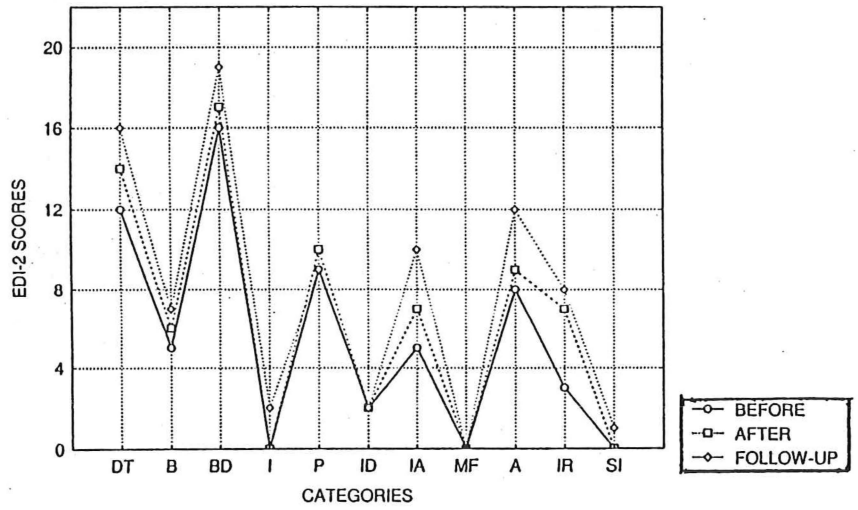

Figure 2.5. EDI-2 Scores For Control Group Participant 2 Before and After the Programme and At 1-Month Follow-up.

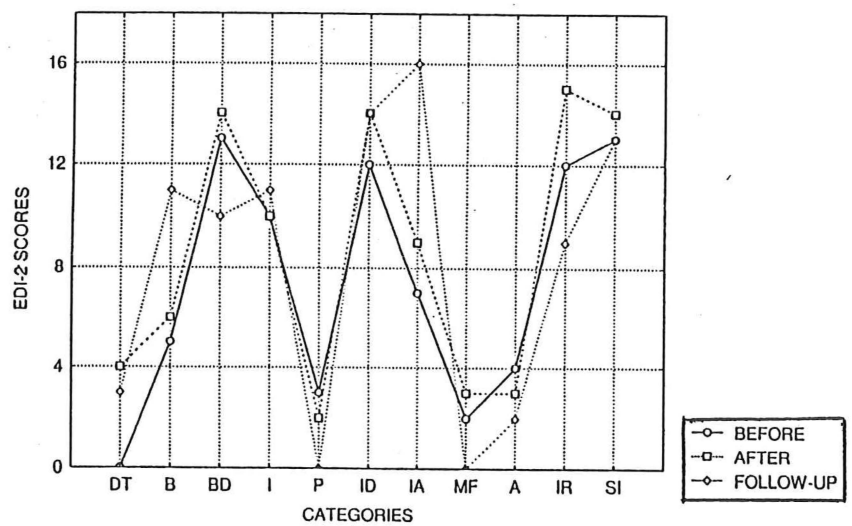

Figure 2.6. EDI-2 Scores For Control Group Participant 3 Before and After the Programme and At 1-Month Follow-up.

increasing from 5 at the first time frame to 11 at follow-up. Interoceptive awareness also showed a noticeable increase, moving from 7 to 16.

At the completion of the programme one might say for two of the three participants the programme had been successful, although at follow-up only one had continued a decreasing trend on the bulimic scale. However it must also be added that one participant from the control group dropped significantly on the bulimic subcategory scale, although the remaining two scored higher at each point in time.

With two subjects showing promising results it caused me to take a closer look at participant 2 to investigate why this was not the case for her. On closer examination participant 2 was of normal weight and on a diet. This was evidence enough for me to consider that she may be a nonpurging bulimic, or that simply being on a diet made her binge eating more severe. The degree of psychopathology often increases with the severity of binge eating, however, other measures such as those for her depression and anxiety did not confirm this idea. Although her depression had increased slightly at follow-up one must always expect such fluctuations in day to day life. Another possibility for the increase on the bulimic subcategory scale could be that the programme made here more aware of her behaviour. A statement such as "I eat when I am upset" could then be answered honestly as "always".

Overall most of the subcategories on the Eating Disorder Inventory-2 were down in the programme group at follow-up, whereas most subcategories for the control group had gone up.

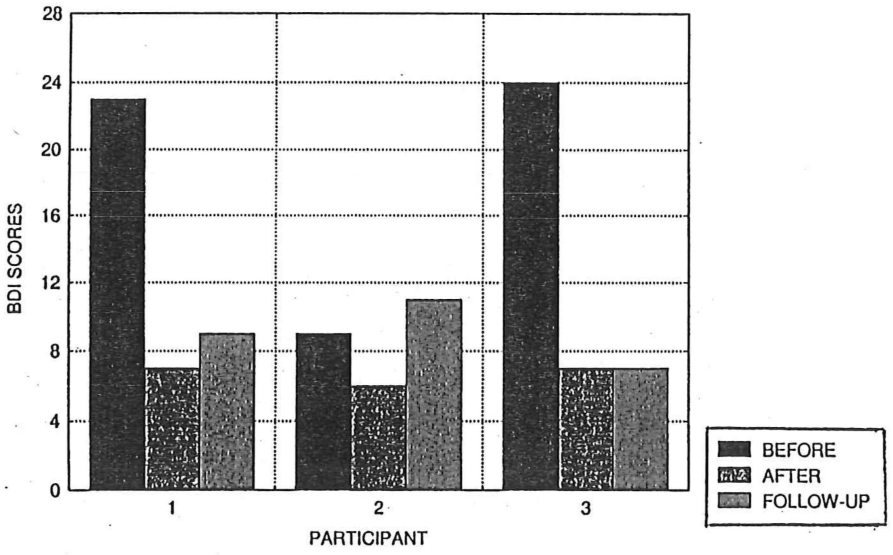

Figure 3.1. Beck Depression Inventory Scores of the Programme Participants Before and After the Programme and At Follow-up.

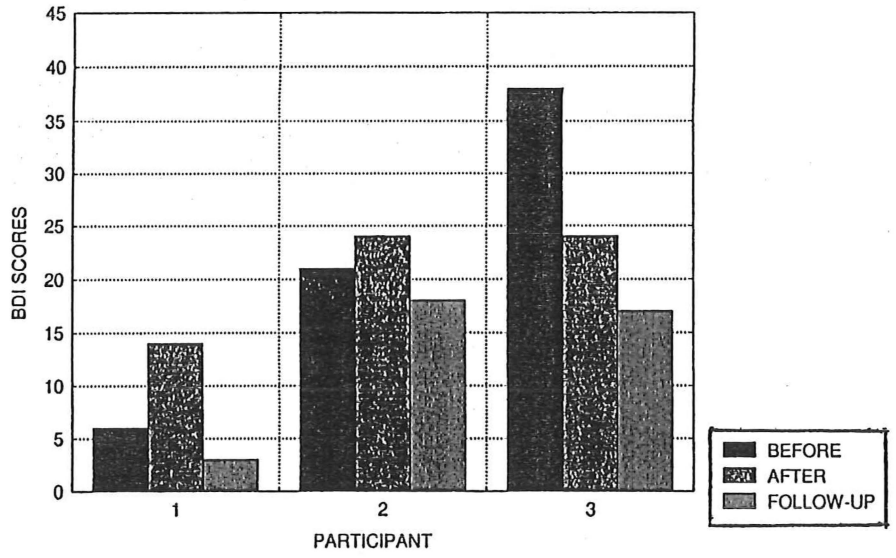

Figure 3.2. Beck Depression Inventory Scores of the Control Group Participants Before and After the Programme and At Follow-up.

3.3. BECK DEPRESSION INVENTORY

Figure 3.1 shows the level of depression on the Beck Depression Inventory for each participant at three points in time. Participant 1 and 3 fell from moderate-severe depression (19-29) before the programme to normal range (0-9) at completion of the programme, while participant 2 fell further within the normal range of depression. At follow-up, participant 1 (although moved up from 6 to 9) remained within the normal range of depression, as did participant 3. Participant 2 fell into the mild range of depression (10-18) at follow-up.

Figure 3.2 shows the level of depression on the Beck Depression Inventory for each of the control group participants at three points in time. Participant 1 rose from normal (0-9) to mild (10-18) and back down to a normal range of depression. Participant 2 fell from moderate-to-severe (19-29) at the first point of time to mild at follow-up. Participant 3 fell from severe (30-36) to a moderate-to-severe range of depression.

Initial scores on the BDI support past literature suggesting that depression is a frequent comorbid disorder among individuals presenting binge eating symptomatology. Even those individuals who do not meet criteria for a diagnosis of depression often report symptoms of depression. The majority of individuals show decreases in depression with improvements in their binge eating (Smith, Marcus & Elderedge, 1994). This is also reflected in this current research where programme participants' depression scores dropped along with their bulimic subcategory scores (excluding participant 2). From those showing high levels on the control group, the same reduction is not present.

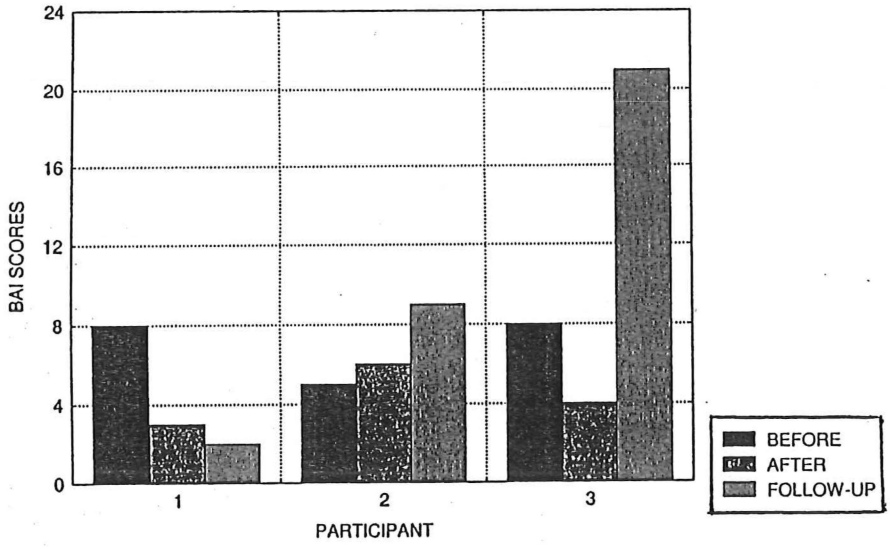

Figure 4.1. Beck Anxiety Inventory Scores of the Programme Participants Before and After the Programme and At Follow-up.

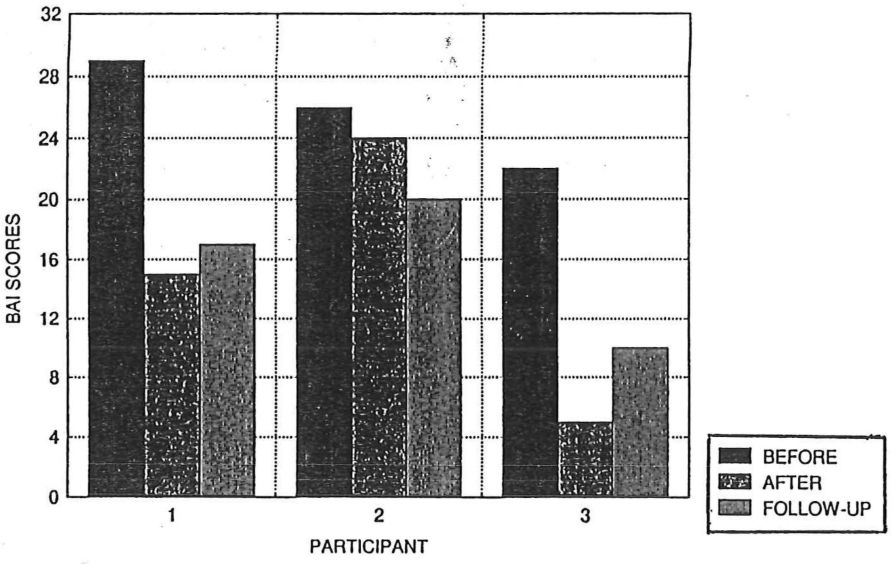

Figure 4.2. Beck Anxiety Inventory Scores of the Control Group Participants Before and After the Programme and At Follow-up.

*At follow-up, participant 3 was ill with a stomach virus which may well have contributed to her score with questions such as having symptoms of "indigestion or discomfort in abdomen".

3.4. BECK ANXIETY INVENTORY

Figure 4.1 shows the level of anxiety on the BAI for each programme participant at three points in time. All participants fell within the normal range of anxiety (0-9) before and after the programme. Participant 1 and 2 remained within this range at follow-up while participant 3 rose to a moderate-to-severe range of anxiety (19-29).

Figure 4.2 shows the level of anxiety on the BAI for each control group participant at three points in time. Participant 1 fell from moderate-to-severe anxiety (19-29) to mild (10-18) at follow-up. Participant 2 remained at moderate-to-severe anxiety at all three points of time. Participant 3, dropped from moderate-to-severe, to normal (0-9), and back up to a mild range of anxiety.

It could be argued that a comparison across the two groups could not be made as all programme group participants were at normal levels of anxiety before treatment, whereas all members of the control group were at moderate-to-severe levels of anxiety. However, individuals suffering comorbid anxiety disorders have not been shown to respond any differently to treatment than those without any anxiety disorder (Smith, Marcus and Elderedge, 1994). Research has shown that anxiety tends to decrease for those with bulimia nervosa following treatment (Agras, Schneider, Arnow, Raeburn and Telch, 1989). Therefore, if the programme group's initial scores had indicated presence of anxiety I would predict that these levels would have decreased at the completion of the programme. The control group's anxiety scores however, remained fairly high.

Table 4. Mean Scores on the Emotional Eating Scale for the Programme and Control Group and a normal population as a comparison.

	Programme Group			Control Group			Normal*
EES 3 Factors	Before	After	Follow-up	Before	After	Follow-up	
Anger/Frustration	48.3	36.3	35	33	38.6	33.3	11.2
Anxiety	32.7	26	23.3	26	25.7	22.3	6.42
Depression	22.7	20	18	19.3	18	20.3	8.1

Table. 4.1. Individual Scores on EES for Programme Group

Participant 1			
EES 3 Factors	Before	After	Follow-up
Anger/Frustration	54/55	40/55	38/55
Anxiety	38/45	24/45	23/45
Depression	23/25	21/25	17/25
Participant 2			
EES 3 Factors	Before	After	Follow-up
Anger/Frustration	44/55	32/55	36/55
Anxiety	27/45	28/45	19/45
Depression	22/25	18/25	16/25
Participant 3			
EES 3 Factors	Before	After	Follow-up
Anger/Frustration	47/55	37/55	31/55
Anxiety	33/45	26/45	28/45
Depression	23/25	21/25	21/25

Table 4.2. Individual Scores on EES for Control Group

Participant 1			
EES 3 Factor	Before	After	Follow-up
Anger/Frustration	30/55	38/55	30/55
Anxiety	24/45	18/45	16/45
Depression	17/25	13/25	20/25
Participant 2			
EES 3 Factor	Before	After	Follow-up
Anger/Frustration	30/55	38/55	29/55
Anxiety	25/45	31/45	23/45
Depression	16/25	17/25	18/25
Participant 3			
EES 3 Factor	Before	After	Follow-up
Anger/Frustration	39/55	40/55	41/55
Anxiety	29/45	28/45	28/45
Depression	25/25	24/25	23/25

* Normal women's data taken from Waller and Osman (1998).

3.5. EMOTIONAL EATING SCALE

Table 4 shows the mean scores on the emotional eating scale for both the programme and control group. As can been seen in the table, while the control group remains relatively stable over the three time periods the programme group shows decreases in all three emotional eating scale factors.

Tables 4.1 and 4.2 show the individual scores on the Emotional Eating Scale for the programme and control group. All programme participants have had reductions in all their EES factors while participants in the control group have remained relatively stable.

Both groups show very high scores compared to those ruled as normal. Although it is disappointing that programme group results at follow-up are not at normal levels, these results do reinforce the growing amount of evidence that binge eating, overeating and bulimic attitudes are associated with disregulation of emotions, therefore strengthening support for research such as this.

Table 5. Means and Standard Deviations on the COPE scale with Programme and Control group and a General Population for Comparison.

Cope Scale	General Pop* N=1030		Programme N=3						Control N=3					
			Before		After		Follow-up		Before		After		Follow-up	
	Mean	Std	Mean	Std	Mean	Std	Mean	Std	Mean	Std	Mean	Std	Mean	Std
1. Active Coping	11.89	2.26	7.3	1.2	10	2	10.3	0.6	8.67	4.5	8.3	4.5	8.7	4.5
2. Planning	12.58	2.26	11.7	1.5	9.67	0.6	11.3	0.6	9.67	3.2	8.67	4	7	4.4
3. Seeking Instrumental Social Support	11.50	2.88	10.67	2.3	13	3.6	13.7	3.2	5.3	2.3	7	3	7	3
4. Seeking Emotional Social Support	11.01	3.46	13.67	2.5	12.67	3.5	15.3	1.2	6.33	3.8	7.3	5	9	2.6
5. Suppression of competing Activities	9.92	2.42	8.3	2.1	10	2	9.7	0.6	5.67	1.5	5.33	2.3	8	2
6. Turning to Religion	8.82	4.10	4	0	4	0	4	0	4	0	4	0	4	0
7. Positive Reinterpretation and Growth	12.40	2.42	10.33	5	10.33	3.5	11.3	3.5	7.33	3.5	8.3	3.5	6.7	3.8
8. Restraint Coping	10.28	2.53	8.33	5	8.67	3.2	9.7	1.5	7	2.6	9	2	7	1.7
9. Acceptance	11.82	2.56	9	3.5	10.33	3.5	10.3	2.3	8.3	2.9	8.3	3.8	9.7	5
10. Focus on Venting of Emotions	10.17	2.53	9.67	2.5	12.67	0.6	12	2	8	1.7	8.3	4.5	9	5
11. Denial	6.07	2.37	8	1	6	1.7	3	1.5	9	4	8.67	6.4	9	6.2
12. Mental Disengagement	9.66	2.46	7.67	2.3	7.67	1.5	7.7	0.6	11	3.5	10.3	3.5	9.7	2.9
13. Behavioural Disengagement	6.11	2.07	9.67	2.3	6.33	2.5	7	3	6.67	1.5	8.66	3.8	6.7	4.6

*General Population scores came from Goldberg (1972).

3.6. COPE SCALE

Table 5 shows the means and standard deviations on the COPE scale with programme and control group and a comparison group. The control group results remained relatively stable throughout the three time periods on all coping scales. The programme participants' results, however, showed some interesting changes, one of which is the coping style 'denial' (an attempt to reject the reality of a stressful event). Both the programme and control group have higher scores at 8 and 9 than the general population at 6.07 on this scale. However the programme group dropped to a 6 and then a 3 at follow-up, while the control group remained at 9 at follow-up. This is a promising result indicating that these individuals are no longer denying stressful events in their life (and undoubtedly eating to do so), but instead are acknowledging that a problem exists.

The programme group showed an interesting increase throughout the three time periods in the use of the coping response 'seeking instrumental social support' (seeking assistance, information or advice about what to do). Before the programme the mean was 10.67 and at follow-up was 13.7. Such an increase in the participant group is not surprising as being part of the programme itself would make one feel they were seeking assistance. Another positive increase was on the active coping scale where the programme group score was 7.3 before the programme, 10 after the programme, and 10.3 at follow-up. The control group scores on this scale however remained stable at 8.67 before the programme and 8.7 at follow-up. These results may be a reflection of the programme, which taught active coping skills for day-to-day life.

Behavioural disengagement (giving up, or withdrawing from the attempt to attain the goal with which the stressor is interfering) scores for the participant group went down from 9.67 before the programme to 6.33 after the programme and 7 at follow-up. The control group scores were the same before and at follow-up at 6.7.

Findings from previous research have suggested that bulimic women do not show a lack of coping strategies but instead the inability to select a coping style that they can use effectively. It is also possible that bulimic women possess the appropriate coping resources but do not see their coping attempts as effective (Weiss Katzman and Wolchik, 1985).

These results indicate there is positive movement within the coping scale for the programme participants suggesting the programme is providing effective skills to better cope with issues in an individual's life.

3.7. GENERAL HEALTH QUESTIONNAIRE

Table. 6. Means and Standard Deviations on the 60-item General Health Questionnaire for the Programme, Control Group and Healthy Females for Comparison.

	Programme N=3			Control N=3			Healthy N=350
	Before	After	Follow-up	Before	After	Follow-up	
Mean	21.3	9.7	9.3	23.7	20.3	8.3	10.41
Std	10	6.7	4	23	11.6	11	11.55

Table 6 shows the means and standard deviations on the GHQ. The programme group dropped from 21.3 to a healthy score of 9.7 at completion of the programme and remained at 9.3 at follow-up. The control group although had a mean of 20.3 at the second point of time, and at follow-up had dropped to a healthy 8.3.

This puzzling result could have been due to a limitation of the questionnaire itself. A problem arises with patients who have very longstanding disorders* and perceive themselves as going through a good phase. With the GHQ method of scoring the questionnaire, the patient does not score unless the symptoms are 'rather more' or 'much more than usual'. This could account for the sudden drop in the control group scores at follow-up.

*This could be the case with binge eaters who often suffer from the disorder for quite some time before seeking help.

CHAPTER 4: DISCUSSION

"Binge eating has little to do with eating and everything to do with effective living. The powerful reinforcement provided by eating in response to emotional cues makes it difficult to stop and presents a challenging coping task. Coping with emotions involves accurate emotional labeling, tolerating anxiety, delaying impulses to eat, and appropriate expression of emotion" (Hawkins, Fremouw and Clement, 1984, p. 66). This is what Goleman would refer to as "emotional intelligence" i.e., knowing our emotions, being self-aware, recognizing feelings as they arise, managing them to effect our aims, handling feelings so that they do not overwhelm, helping us soothe ourselves, manage our anxiety, anger and sadness, control impulses, motivate ourselves, and to handle relationships successfully. Those who know and manage their own feelings well and who read and deal effectively with other people's feelings, are at an advantage in any area of life. Those who find it difficult to manage their emotional life can fight inner battles (Goleman, 1995). The main rationale of this thesis was to design a psychoeducational group programme teaching emotional discrimination and management for women with binge eating disorder and to assess its impact on the participants. In essence, to teach "emotional intelligence".

4.1. WHAT EFFECT DID THE PROGRAMME HAVE?

From the data obtained we can see the suggestion of some positive results. In summary, on the EDI-2 although scores are not at normal levels at the completion of the programme or at follow-up, there was a decreasing trend over time for the

participants, as opposed to the increasing trend seen in the control group. While depression dropped and anxiety remained low in those that participated in the programme, these same drops were not present in the control group. A decreasing trend was also observed on the emotional eating scale for those individuals in the programme (although scores remained at higher than normal levels). In comparison, the control group remained relatively stable at their original level. Positive changes on the COPE scale were also present in the programme participants, but not the control group. The GHQ showed less clear results.

4.2. ISSUES TO BE ADDRESSED

There are many limitations of this study. Various methodological concerns make it difficult to evaluate the impact of the programme. Lack of replication across cases occurred due to a small sample. A multiple baseline across cases design would have been desirable to establish the effectiveness of the programme. In addition, a wait-list control group was not used, although this would have provided a comparison across all stages of treatment.* A visual time series analysis through the use of the daily monitoring sheets could also have provided valuable data. In addition, monitoring sheets could have been used not only to monitor emotions and eating but other behaviour, to ensure that the participants were learning what was being taught. This could also have tested the internal validity of the programme. Although not of major

* A wait-list control group was to be employed, however due to problems with drop-outs the second run of the programme was cancelled.

concern to this particular study, participants were referred to as having binge eating disorder, although not assessed so as to be clinically diagnosed as such.

It could be argued that the programme itself might have been made more effective by increasing the number of sessions. Eight sessions in 6 weeks is relatively short in comparison to other treatment programmes. For example Fairburn's CBT programme developed for BED involves 22 sessions in 24 weeks. According to the literature this number appears to be standard. In fairness however, it must be pointed out that short treatment programmes have been shown to be effective. In the Connor-Greene (1987) study, the group treatment for bulimia nervosa ran weekly for six weeks. Five of the four patients reported a decrease in binge frequency and four reported a reduction in self-induced vomiting. At the conclusion of the programme all reported feeling in control of their eating in contrast to their feeling a loss of control at the beginning. A short treatment approach does have its limitations in how much can be gained in each session though. Issues such as self-esteem, perfectionism, cultural expectations of thinness for women, enhancing body image and many more could have been included in this programme had the number of sessions allowed for it.

Another issue I feel should be addressed is that of group sessions. It soon became clear that participants in the programme were finding different aspects of the programme more helpful than others. One found relaxation very helpful in dealing with stressful situations that previously would have triggered a binge. Another did not have much success using her relaxation technique but found a comment on nutrition raised in a discussion time stopped her from bingeing on a number of occasions.

Individual sessions have the advantage of being able to plan the treatment around what is best suited for the participant. The reason why people respond differently to treatment is often due to the different causes of the disorder. For example in reference to the three theories on emotional eating, discussed above, although heightened emotionality and loss of control with feelings of hunger and satiety are central to all three theories, they differ in their assumptions as to the cause of these. Psychosomatic theory emphasises the internal instigation of eating and thus the focus is on emotional factors. Those individuals who tend to eat in response to emotional states are considered maladjusted and thought to suffer from unstable emotionality. The externality theory emphasizes the external instigation of eating, thus the focus is on the trait of externality. Heightened emotionality is regarded as an aspect of externality as a personality trait. Both theories state that overeating and weight gain result in dieting. The theory of restraint, however, argues that dieting may lead to overeating and weight gain, and thus the theory focuses on the side effects of diets. Emotional eating and heightened emotionality are considered side effects of dieting, as is loss of contact with feelings of hunger and satiety (van Strien, 1991).

Because the theories differ about why individuals overeat, this has consequences for designing treatment. According to psychosomatic theory treatment should focus on psychological treatment. Weight or eating behaviour can never be treated per se, since overeating is likely to be only a symptom of underlying emotional problems. In externality theory, treating external responsiveness, the outcome of an external cognitive style, is the focus for dealing with overweight. Techniques for controlling food environment and food-related stimuli are provided, such as eating in one place only. For the theory of restrained eating, treatment involves teaching individuals to

accept their own 'natural weight' and to return to 'natural eating' through a 'natural weight undiet' procedure (Polivy and Herman, 1983).

It can be taken from these three theories that people differ in their reasons for overeating. Some overeat in a state of negative emotions, some in response to strong food-relevant stimuli, some when "going off" a diet. I observed such differences in my group. What this may mean is that people bingeing for different reasons need specific types of treatment. In order to decide the best treatment for a specific type of eating behaviour, the eating-behaviour pattern must be assessed. The Dutch Eating Behaviour Questionnaire (DEBQ; Van Strien, Frijiters, Bergers and Defares, 1986) has been developed for such a purpose with separate scales for emotional, external, and restrained eating behaviour. It is made up of 33 items. 10 on restrained eating, 10 on external eating and 13 on emotional eating.

A sample of items from DEBQ.

Restrained eating

a) Do you deliberately eat less in order not to become heavier?

b) How often do you try not to eat between meals because you are watching your weight?

Emotional eating

a) Do you get a desire to eat when you are anxious, worried or tense?

b) Do you have a desire to eat when someone lets you down?

External Eating

a) If you see or smell something delicious, do you have a desire to eat it?

b) When preparing a meal, are you inclined to eat something?

When overeating is a symptom of underlying emotional problems, diet programmes or behaviour control procedures are going to fail. All good intentions with regards to

weight loss are easily set aside during stress or in a state of negative emotions. The best treatment is one which suits the specific pattern of eating behaviour of the individual. A limitation with this programme was that it was not designed in a way that allowed individual issues to be addressed, and thus the DEBQ was not used as a scale. However, in retrospect, the DEBQ would have been useful in this study to provide information as to *why* the participants binged, and should be used in any subsequent studies.

Whatever the cause of the problem, whether it be lack of nutritional information, perfectionism, lack of self-esteem, adherence to the female sex-stereotype - which on reflection are all aspects that I would have liked to have addressed in my sessions - it is the inability to recognize and/or manage the negative emotion resulting from the problem that precipitates the binge. Gloria Leon conducted a study of young girls and eating disorders and observed that these girls "have poor awareness of their feelings and body signals; that was the strongest predictor that they would go on to develop an eating disorder within the next two years. Most children learn to distinguish among their sensations to tell if they're feeling bored angry or depressed, or hungry – it's a basic part of emotional learning. But these girls have trouble distinguishing among their most basic feelings. They may have a problem with their boyfriend, and not be sure whether they're angry, or anxious, or depressed – they just experience a diffuse emotional storm that they do not know how to deal with effectively. Instead they learn to make themselves feel better by eating; that can become a strongly entrenched emotional habit..." (Goleman, 1995, p. 248). Leon believes that effective treatment for such girls needs to include some remedial instruction in the emotional skills that they lack. "These girls need to learn to identify their feelings and learn ways to

soothe themselves or handle their relationships better, without turning to their maladaptive eating habits to do the job" (Goleman, 1995, p. 249).

Emotional discrimination and management should be a central part of treatment for binge eating disorder, with additional treatment depending on the individual's eating-behaviour pattern. This may require treatment to be at an individual level, or perhaps group sessions involving emotional recognition and management and one-on-one sessions for individual issues. There is no doubt that there is an abundance of room for further research in the area of emotions and binge eating disorder.

It is difficult to assess those 'at risk' of developing binge eating disorder. Unlike IQ, there is, as yet, no single paper-and-pencil test that yields an "emotional intelligence score" and there may never be one. However, certainly in terms of prevention for binge eating disorder, it must go much further that providing information to adolescent girls on the drawbacks of dieting, the dangers of eating disorders, and to providing correct nutritional information. Take for example the growing number of cases of sexual abuse in the United States reported annually. In an effort to prevent sexual abuse many schools have begun to offer programmes which focus mainly on basic information about sexual abuse. For example, teaching children to know the difference between 'good' and 'bad' touching, to teach them of the dangers and encourage them to tell an adult if anything happens to them. However, a national survey of two thousand children found this training to be even worse than no training at all. Children having had such basic training and who had subsequently become victims of sexual assault, were half as likely to report it than those children who had had no training at all. In contrast, children given more comprehensive training,

including related emotional and social competencies were better able to protect themselves from being victimized, far more likely to demand to be left alone, to yell or fight back, to threaten to tell, and to actually tell if something did happen to them. These more comprehensive programmes were not one-shot topics but were given at different levels at several times in the child's schooling. Beyond this it was the social and emotional competencies that made the difference. It was not enough for a child to know about 'good' or 'bad' touching but to have the self-awareness to know when a situation *feels* wrong or distressing in advance of the touching begining. In addition to self-awareness the child also needs enough self-confidence and assertiveness to trust and act on those feelings of distress (Goleman, 1995). There is much to be said about formally introducing such 'life skills' classes into a child's schooling, to prevent future problems, potentially including the development of binge eating disorder.

4.3. CONCLUSION

Despite the limiting features of this research it could be concluded that emotional discrimination and management may contribute to effective treatment for binge eating disorder in young women. More research is required before any firm conclusions can be drawn. The study challenges an issue I feel all clinicians need to address regarding eating disorders. Because binge eating provides immediate negative reinforcement by reducing negative affect, eating becomes a way of dealing with problems and becomes a habit, which is difficult to break. Although binge eating provides a temporary alleviation from emotional distress, it generally leads to an increase in negative feelings longer-term. As a result, the emphasis in treatment has been on the

'disordered eating' rather than the initial problem. Anorexia, bulimia nervosa, and binge eating disorder have been given their clinical names for obvious reasons. It is not uncommon that a given name of a disorder describes the most obvious psychopathological behaviour - and in this case behaviour that often has severe consequences. However, to provide appropriate treatment, I believe it would be beneficial to keep at the forefront of the mind that the 'disordered eating' is one component amongst an array of different individual difficulties. I am not suggesting the 'disordered eating' is any less important to treat, but that perhaps a shift in focus for treating eating disorders is well overdue.

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APPENDIX 1
PROGRAMME MANUAL

MANUAL FOR TRAINING EMOTIONAL DISCRIMINATION AND EMOTIONAL MANAGEMENT FOR WOMEN WITH BINGE EATING DISORDER

SESSION 1

Introductions to be made - everyone to be given a name badge.

Give all participants handout that explains the programme structure, content, outcome, style and need for commitment, expectations as a group member and confidentiality. Go through the handout with the group.

Progamme Structure : The programme comprises of 8 sessions over 6 weeks. The sessions are up to 2 hours in length. They always begin on time and it is important to keep to the allocated time.

Programme content : The rationale behind the programme will be explained. The programme will teach you to cope more effectively with the circumstances that tend to result in binge eating by being taught how to recognise and manage your emotions more effectively, as well as establishing a pattern of regular eating. The programme will also look at how you can maintain and increase these positive changes.

Programme outcome : 1. To help you gain a personal understanding of the link between circumstance, feelings and behaviour. 2. To help you increase mastery over your emotions through emotion discrimination and management. 3. To help improve your eating habits. However, it is not helpful to think that you will be "cured" - you may remain vulnerable. But the skills you learn in the course will give you a lifelong ability to cope effectively with negative circumstances and feelings.

Programme style and need for commitment: This type of programme needs full commitment. It needs to be given priority in your life. Regular homework assignments will be set after each session, and you should do your utmost to complete them. The more effort that is put into the programme, the greater will be the rewards. Also, as a group member you have a role to play as a participant and by not fulfilling this role it can be very disruptive for the rest of the group members. You must also be clear that this is not a weight loss programme. The primary aim is to develop your capacity to identify feelings clearly and express feelings effectively. You must also acknowledge and respect the privacy of others in the group. Confidentiality is expected of all group members. (Talk about what confidentiality means).

I _____ agree to accept my responsibilities as a group member of this programme and in respect for the privacy of others in the group assure confidentiality.

Signed Date

Check that everybody is clear about this handout. Answer any questions they may have regarding this.

I'm now going to discuss with you the rationale behind the programme.

Rationale of Programme.

As we go through this remember that this is an overview of the whole programme. We will go back in detail over each point later.

This eight-week programme will be spent concentrating on learning how to recognise and cope with emotions in a more productive way. The reason why we are going to do this is because there has been a lot of research done that suggests that binge eating episodes are usually triggered by some form of emotional distress.

What is the effect that emotions have on eating? We can identify two different groups of people.

1. There are those people that cannot eat when they are emotionally distressed. They literally feel ill if they do because their stomach is too churned up.

2. Other people are the opposite and eat when they are emotionally distressed. These are the people that are susceptible to binge eating. If the people from this group diet then this adds to their vulnerability to binge.

What is the effect that eating has on emotions?

1. Comfort. One has the pleasurable activity of eating "forbidden food" – nice-tasting, hunger-reducing food, it is a distraction (although short-lived) from other current problems, and serves as a temporary alleviation of feelings of depression and anxiety.

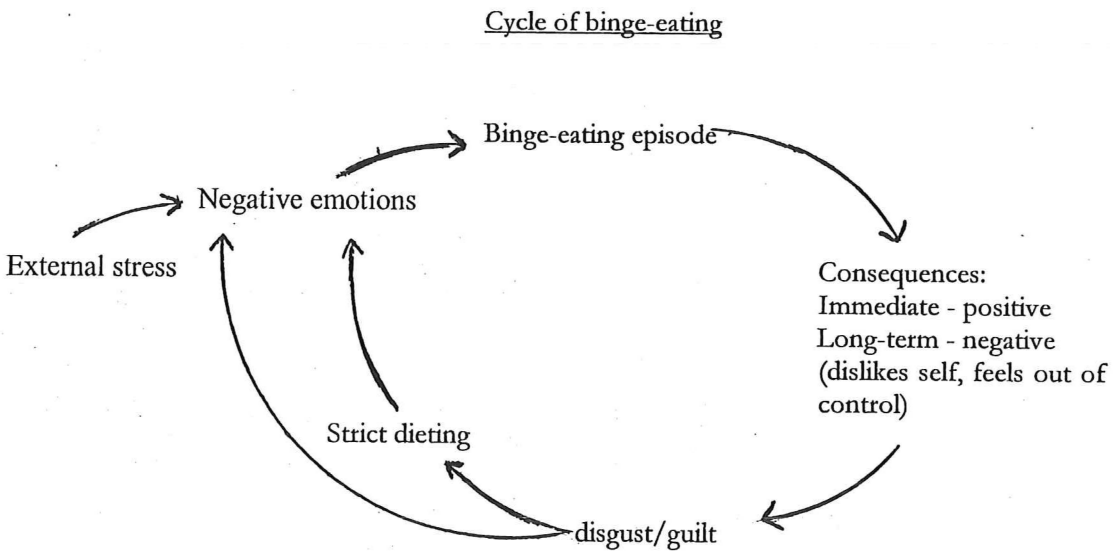
2. Eating in response to distress may become a habit. If at any point one feels overwhelmed, they can call upon the structure of binge eating to organize their thoughts and behaviour because of the highly ritualized and repetitive nature of the action. Narrowing attention into routine patterns helps distract the individual from broader concerns. When a person is under stress it always feels good to do something familiar. One strategy you have is by binge eating.

But:

1. It makes you feel worse in the long-run.
2. You become worse at discriminating emotion. You know that you are "upset" but not clear exactly how or why. If a person is reluctant to engage in meaningful thought, critical evaluation of novel ideas is even less effective than usual. Also if a person is avoiding negative emotions all the time then their tolerance to negative emotions decreases.

Question: Could you become a wine connoisseur without ever drinking wine? Can you become an expert in discriminating your emotions without feeling them?

Here is a model to explain the role that emotions play in your disorder. (put this up on the OHP)



Like many women, you are anxious to look your best, and concerned about weight and fat, you may be on a diet. For reason relating to our physiology, being on a diet makes us vulnerable to binge eating. An external stress occurs, say for example, an argument with your partner or family member, which has left you feeling very angry. This negative emotion triggers a binge of a banned or forbidden food from your diet. The binge has the short-term/immediate effect of making you feel better. It initially produces a sense of satisfaction or nurturance, by "blocking out" a current bad feeling or negative situation. But eventually you feel guilty for doing so which brings back negative feelings of disgust, defeat, guilt etc., and so the cycle of binge eating continues.

There are other ways at looking at binge eating though. For example, writer Susie Orbach distinguishes between being "stomach hungry" which is genuine physical hunger, and "mouth hungry" which is hunger for something other than food – for attention, rest, stimulation, comfort, or love. She sees binge eaters as mouth-hungry eaters. All feelings are labeled as hunger. Eating becomes the way to deal with feelings. You eat when you are tired, anxious, angry, lonely, bored, hurt or confused. Some of you may be able to identify with this.

Interactive Part

Can you think of any other ways that people avoid feeling their emotions and the pain associated with their emotions? Make list on whiteboard of suggestions, make sure those below are mentioned.

- Some **withdraw** from or **avoid situations** that evoke disturbing emotions.
- Others **ignore** or **do not acknowledge** what they are feeling.
- Some people use **distractions such as keeping busy.**
- Some transform their feelings into **psychosomatic complaints**. E.g., stomach ache
- Others engage in **stimulus-seeking** or **impulsive behaviour** in order to shut out their feelings.
- **Binge eating is an extreme numbing behaviour that is an attempt to dissociate from the painful feeling and to self-soothe.**
- Drugs and alcohol are a similar numbing behaviour to binge eating.

We can see from our list that people find many ways to avoid feeling their emotions and the pain associated with their emotions, and use different ways to control emotional reactions. *Can you come up with some ideas on why binge eating is not good for you?* Binge eating is a self-defeating pattern of behaviour. It is an attempt to control emotions so they are not overwhelming, but this is futile for two reasons (reasons stated at beginning – makes you feel worse in the long run, and you become worse at discriminating). So by avoiding emotions we leave ourselves doubly deficient.

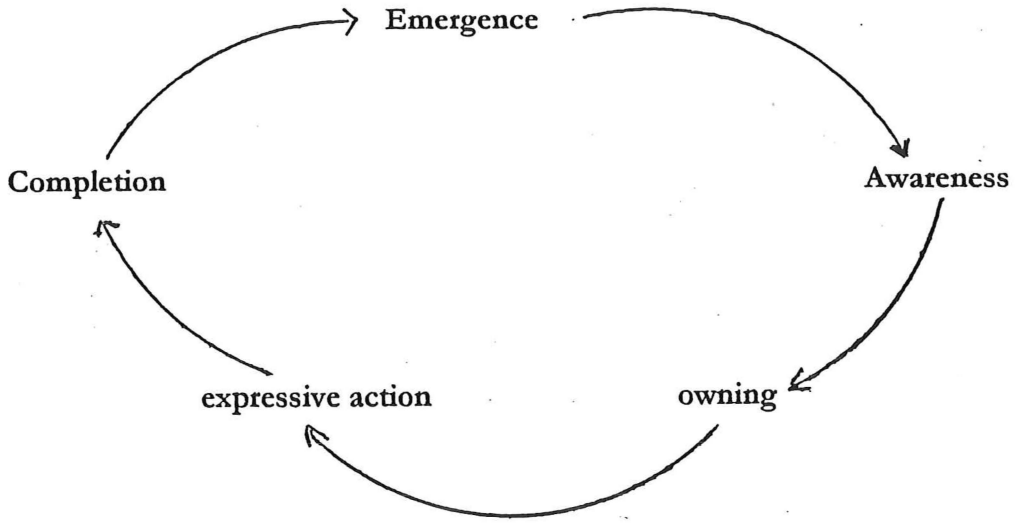
Why are emotions important?

Emotions function as a cue to action. They act as a guide to do the necessary appropriate thing. They enhance our capacity to cope and, once accepted, can better be coped with themselves.

There is a natural process of emergence and completion with feelings and emotions. This spontaneous process of arising and passing away occurs because many feelings involve an automatic process over which we have little conscious control. To some degree, we can manage what we feel, but we can do little to prevent the automatic

emergence of many feelings. Because we cannot control these affective experiences, we need to learn to accept our feelings and learn from them.

Think of feeling as a set of phases, (write this up on the board).



Followed again by the emergence of a new feeling beginning the cycle again. It is when this process is chronically interfered with, when, for example emergence or identification is prevented, or expression is continually interrupted or some form of action is blocked - that people become stuck in a chronic bad feeling, becoming dysfunctional and chronically distressed.

I want to now introduce a new concept - **emotional intelligence.** IQ intelligence has always been used to predict who will succeed in life. But some experts suggest that IQ only contributes about 20% to the factors that determine life success, which leaves 80% to other forces. These other factors or characteristics are things such as the ability to be able to motivate oneself and persist in the face of frustrations; to control impulse and delay gratification; to regulate one's moods and keep distress from swamping the ability to think; to empathize and to hope. This is emotional intelligence (EQ). Academic intelligence offers virtually no preparation for the turmoil or opportunities that life can bring. A high IQ is no guarantee of prosperity, prestige, or happiness in life. Emotional intelligence however, matters immensely for our personal destiny. Emotional life is a domain that as surely as say maths, can be handled with greater or lesser skill, and requires its unique set of competencies. And how adept a person is at those is crucial to understanding why one person thrives in life while another, of equal intellect, fails. Much

evidence testifies that people who are emotionally adept – who know and manage their own feelings well, and who read and deal effectively with other people's feelings – are at an advantage in any area of life, whether romance and intimate relationships or in the workplace. People with well-developed emotional skills are also more likely to be content and effective in their lives, mastering the habits of mind that create their own productivity; people who find it difficult to manage their emotional life can fight inner battles that destroy their ability for focused work and clear thought. So emotional intelligence is: (List these on OHP)

-knowing your emotions *and*
-being self-aware. *This means*
-recognising our feelings as they arise *and being able to*
-manage them to effect our aims. *Being aware helps us*
-handle feelings so that they do not overwhelm *and*
-help us soothe ourselves *and*
-manage our anxiety, anger and sadness. *This emotional intelligence also involves*
-controlling impulses *and*
-being able to motivate ourselves. *In addition, emotional intelligence entails*
-the ability to recognise emotions in others *and thereby*
-to handle relationships successfully.

So this program will help you become more emotionally intelligent. It will help you understand the feelings you have, and their meaning for your life and circumstances. It will give you the power to use your emotions rather than blocking them. Blocking feelings simply prevents effective coping/dealing with the source of the problem. When painful feelings are attended to and accepted, the pain can be endured and/or reduced and can be used as information to let you know that something is not right and some action needs to be taken to change yourself and/or your situation. You will develop the capacity to identify feelings adequately and express feelings effectively - Emotional discrimination and management. The sooner you learn to be open to and accept your feelings, the sooner you are able to benefit from the information contained within them and the better you are able to cope with the world and their emotions.

BREAK

Introduce everyone to the idea of monitoring.

The purpose of self-monitoring is twofold: first, it provides a detailed picture of how you eat, thereby bringing to your attention the exact nature of your eating problem; and second, by making you more aware of what you are doing at the very time that you are doing it, self-monitoring helps you change behaviour that previously seemed automatic and outside your control. Accurate self-monitoring is a very important part of the programme. At first, writing down everything you eat and everything you feel may well be irritating and inconvenient, but soon it will become second nature and of obvious value. It is unlikely that anyone's lifestyle makes monitoring truly impossible.

Give everyone a handout explaining how to monitor. Go through the handout. A handout to be given of someone's monitoring sheet as an example.

MONITORING

Column 1 is for noting the time when you eat or drink anything.

Column 2 should specify where the food or liquid was consumed. If this was in your home, the room should be specified.

Column 3 should be used as a diary to record events that influence your eating; for example, if an argument precipitated a binge, you should note that down. You may wish to record other important events, even if they had no effect on your eating. You should also note down all strong feelings, for example, feelings of depression, anxiety, boredom or loneliness, or feeling fat.

Column 4 is for recording the nature of the food or liquid consumed. Calories should not be recorded: Instead, you should provide a simple (non-technical) description of what you ate or drank. Each item should be written down as soon as possible after its consumption. Recalling what you ate or drank some hours earlier is not satisfactory, since it will not help you change your behaviour. Episodes of eating that you viewed as meals should be identified with brackets. Snacks and other episodes of eating should not be bracketed.

Asterisks should be placed in Column 5 adjacent to any episodes of eating that you felt at the time were excessive or out of control.

Column 6 should be used to write down the emotion that you are feeling at this particular time. Use the Feelings Chart provided to help you identify what emotion you are feeling.

Feelings Chart

Happiness	**Sadness**	**Anger**	**Love and Friendship**	**Fear**	**Distress**
		High level of feeling			
elated	miserable	fuming	adoring	dreadful	anguished
giddy	crushed	furious	devoted	panicky	disgusted
overjoyed	worthless	outraged	passionate	horrified	speechless
radiant	humiliated	incensed	amorous	terrified	tormented
ecstatic	depressed	burned up	tender	petrified	sickened
jubilant	helpless	hateful	ardent	desperate	afflicted
		Moderate level of feeling			
tickled	forlorn	disgusted	caring	alarmed	badgered
glowing	burdened	irritated	dedicated	fearful	bewildered
excited	slighted	aggravated	generous	jittery	confused
joyous	abused	biting	loving	strained	disturbed
bubbly	defeated	hostile	empathic	shaky	impaired
delighted	dejected	riled	considerate	threatened	offended
		Low level of feeling			
amused	resigned	peeved	warm	uneasy	silly
cheerful	apathetic	bugged	amiable	tense	foolish
pleased	blue	annoyed	civil	timid	unsure
relieved	gloomy	ruffled	polite	anxious	touchy
glad	ignored	nettled	giving	nervous	lost
serene	glum	cross	kindly	puzzled	disturbed

Monitoring- Name_____

Day_____ Date_____

Time	Location	Context	Food and liquid consumed	B	Emotion Recognition

Obviously, if you are to record in the way that you are being asked, you will have to carry your monitoring sheets with you. Every treatment session will include a review of your latest monitoring sheets. You must therefore remember to bring them. Ask if everyone understands this information. Give everybody a monitoring sheet and do a quick practice exercise in class of what they ate today to double check they understand what they are suppose to do.

Give everyone their questionnaires to fill out.
Homework assignment.
What I want you to do over the next week is to monitor your eating and emotions every day. You will be doing this over the entire programme. I'll give you all enough monitoring sheets until our next session.
Next week we will be spending some time looking at your monitoring sheets. We will also begin to look at the importance of recognising emotions.

SESSION 2

The first thing we are going to do today is to review your monitoring sheets. We will do this briefly at the beginning of every session but today I want to spend quite a bit of time on them.

I'd like you to get into pairs and just talk to the other person about how you found it, if you had any difficulties, if so what were they, if you can sees any sort of pattern to your eating habits and emotions. Anything at all. Then we'll come back as a group and discuss these things. (Go round the group and talk to each pair). Write up on board problems and difficulties and discuss as a group.

<u>The Importance of Emotions</u>

As this treatment is focusing on emotions, I want to talk some more about the importance of emotions.

Emotions guide us in situations and tasks that are too important to leave to intellect alone. For example, danger, painful loss, building a family. As you will all know from

experience, when it comes to shaping our decisions and our actions, feeling counts just as much - and often more - than thought.

I want you to get into pairs and come up with some ideas on how a person **behaves** or **acts** when they are angry, sad, in love, in fear. Then we will come back as a group and discuss these things. Write down suggestions as well as those listed below.

Expressing/ *acting on anger*

Frowning or not smiling; mean or unpleasant facial expression.

Gritting or showing your teeth in an unfriendly manner.

Grinning.

A red or flushed face.

Verbally attacking the cause of your anger; criticizing.

Physically attacking the cause of your anger.

Using obscenities or cursing.

Using a loud voice, yelling, screaming, or shouting.

Complaining or bitching; talking about how lousy things are.

Clenching your hands or fists.

Making aggressive or threatening gestures. Pounding on something, throwing things, breaking things.

Walking heavily or stomping; slamming doors, walking out.

Brooding or withdrawing from contact with others.

Expressing/ *acting on sadness*

Frowning, not smiling .

Eyes drooping.

Sitting or lying around, being inactive.

Making slow, shuffling movements.

A slumped, drooping posture.

Withdrawing from social contact.

Talking little or not at all.

Using a low, quiet, slow or monotonous voice.

Saying sad things.

Giving up and no longer trying to improve.

Moping, brooding, or acting moody.
Talking to someone about sadness.

Expressing/*Acting on Love*
Saying "I love you".
Expressing positive feelings to a person.
Eye contact. Mutual gaze.
Touching, petting, hugging, holding, cuddling.
Smiling, laughing.
Sharing time and experiences with someone.
Doing things that the other person wants or needs.

Expressing/*acting on Fear*
Engaging in nervous, fearful talk.
A shaky or trembling voice.
Crying or whimpering.
Screaming or yelling.
Pleading or crying for help.
Fleeing, running away.
Running or walking hurriedly.
Hiding from or avoiding what you fear.
Trying less or becoming speechless.
Frozen stare.

If you look at these lists carefully and see what people do when they are feeling a particular emotion you can see that all emotions are basically impulses to act, and each plays a special role (briefly point out on the board the actions that are occurring with each emotion). Lets look at the physiological details of how each emotion prepares the body for very different responses.

With anger blood flows to the hands, making it easier to grasp weapons or strike an enemy. Heart rate increases, and a rush of hormones such as adrenaline creates energy

strong enough for vigorous action (point out the number of physical aspects that go with the anger behaviour on the board).

With fear blood goes to the large muscles, such as the legs, making it easier to flee - this makes the face and skin pale as blood moves away from it (creating the feeling that the blood "runs cold"). At the same time the body freezes, maybe to decide whether hiding might be a better reaction. A flood of hormones puts the body on general alert, making it edgy and ready for action, and attention narrows to focus on the threat at hand to better evaluate what responses to make (point out these action that have been written about fear)

Love, tender feelings and sexual satisfaction create a relaxation response, where a bodywide set of reactions generates a general state of calm and contentment, facilitation cooperation (point out these sorts of actions on the board).

A main function for sadness is to help adjust to a significant loss such as the death of someone close. Sadness brings a drop in energy and enthusiasm for life's activities and, as it deepens and approaches depression, slows the body's metabolism. This all creates the opportunity to mourn, and as energy returns, plan new beginnings (show how this links with the sad actions written on the board).

The important point that I am trying to make is that emotion is not opposed to reason. An important function of emotions is to prompt behaviour. Emotions guide and manage thought and action in fundamental ways and complement thinking.

Homework
Monitoring of eating and emotions and recognising emotions.

Rundown of next session
Next week we will be talking more about emotions.

SESSION 3

Greetings etc.

I want you to get into pairs again and discuss how you found your monitoring this week. I will come round and have a word with all of you.

I want to talk briefly about regular eating and give you some ideas on how to do this.

You need to restrict your eating to three planned meals each day, plus two or three planned snacks. There should rarely be more than a 3-hour interval between the planned meals and snacks, and you should always know when you are next going to have a meal or snack. This eating pattern should take precedence over other activities; irrespective of your circumstances or appetite, you should not skip the meals or snacks. Conversely, between these times you should do your utmost to refrain from eating. Thus your day should be structured by this pattern of regular eating.

Introducing this eating pattern has the effect of displacing the alternating overeating and dietary restriction of your eating habits. Obviously the pattern must be tailored to suit your daily commitment, and may need to be modified to accommodate weekends. If a particular day is unpredictable, you should plan ahead as far as possible and identify a time to take stock when you can then plan the remainder of the day.

Eating meals and/or snacks is unlikely to result in weight gain. Dieting not only slows down your metabolism, but it makes you feel miserable and makes you more susceptible to bingeing. Negative self-statements such as "I can never eat what I like" demoralise people and decrease their motivation to adhere to the diet program. The introduction of a pattern of regular eating will decrease your frequency of binge eating and thereby significantly reduce your overall energy intake.

To adhere to the pattern of regular eating identify pleasurable activities that are incompatible with binge eating. These activities may be used to cope with times between meals and snacks when you have an urge to overeat, thereby reducing the likelihood of binge eating. You should keep "one step ahead of the problem". You should predict

when difficulties are likely to arise and at these times engage in activities incompatible with binge eating. Such an activity may include telephoning or visiting friends, taking some form of exercise, or having a bath or shower. Using your monitoring sheets you will be able to better identify high-risk situations. *Lets have some group input on ideas for alternative behaviour. Things that you enjoy doing. (list these on the board).*

Now I want to pick up where we left off in our last session on emotions. The point was made that emotions are basically impulses to act. I want to now talk about the initial impact of an emotion. What is it we ***feel*** with a certain emotion. I want you to get into pairs and come up with some ideas on what a person **feels** or **experiences** when they are angry, sad, in love and in fear. Then we will come back as a group and discuss these things. Write down suggestions as well as those listed below.

Feeling/Experiencing *anger*

Feeling incoherent.
Feeling out of Control.
Feeling extremely emotional.
Feeling tightness or rigidity in your body.
Feeling your face flush or get hot.
Feeling nervous tension, anxiety, or discomfort.
Feeling like you are going to explode.
Muscles tightening.
Teeth clamping together, mouth tightening.
Crying, being unable to stop tears.
Wanting to hit, bang the wall, throw something, blow up.
Narrowing of attention.
Attending only to the situation making you angry.
Ruminating about the situation, making you angry and not being able to think of anything else.
Remembering and ruminating about other situations that have made you angry in the past.
Imagining future situations that will make you angry.
Depersonalization, dissociative experience, numbness.
Intense shame, fear, or other negative emotions.

Feeling/ experiencing *sadness*

Feeling tired, run-down, or low in energy.

Feeling lethargic, listless, wanting to stay in bed all day.

Feeling as if nothing is pleasurable any more.

Feeling a pain or hollowness in your chest or gut.

Feeling empty.

Crying, tears, whimpering.

Feeling as if you can't stop crying, or feeling that if you ever start crying you will never be able to stop.

Difficulty swallowing.

Breathlessness.

Dizziness.

Feeling irritable, touchy or grouchy.

Having a negative outlook thinking only about the negative side of things.

Blaming or criticizing yourself.

Remembering or imagining other times you were sad and other losses.

Hopeless attitude.

Not being able to remember happy things.

Fainting spells.

Nightmares.

Insomnia.

Appetite disturbances, indigestion.

Yearning and searching for the thing lost.

Depersonalization, dissociative experiences, numbness, or shock.

Anger, shame, fear, or other negative emotions.

Feeling/experiencing *fear*

Sweating or perspiring.

Feeling nervous, jittery or jumpy.

Shaking, quivering, or trembling.

Darting eyes or quickly looking around.

Choking sensation, lump in throat.

Breathless, breathing fast,

Muscles tensing, cramping.

Diarrhea, vomiting.

Feeling of heaviness in stomach.

Getting cold.

Hairs erect.

Losing your ability to focus or becoming disoriented.

Being dazed.

Losing control.

Remembering other threatening times, other times when things did not go well.

Imagining the possibility of more loss or failure.

Depersonalization, (a feeling of loss of self or of personal identity), numbness, or shock.

Intense anger, shame or other negative emotions.

***Feeling/experiencing** love*

When with someone or thinking about someone:

Feel excited and full of energy.

Fast heartbeat.

Feeling and acting self-confident.

Feeling invulnerable.

Feeling happy, joyful, or exuberant.

Feeling warm, trusting, and secure.

Feeling relaxed and calm.

Wanting the best for a person.

Wanting to give things to a person.

Wanting to see and spend time with a person.

Wanting to spend your life with a person.

Wanting physical closeness of sex.

Wanting closeness.

Only being able to see a person's positive side.

Feeling forgetful or distracted; daydreaming.

Feeling openness and trust.

Remembering other times and people you have loved.

Remembering other people who have loved you.

Remembering and imagining other positive events.

It is important that you recognise your emotions when you are feeling or experiencing them so that you can respond in an appropriate manner. If you are having difficulty in doing this it may be helpful to you if you think about what may have prompted you to feel a certain way.

I want you to get into pairs again and come up with some ideas of what event or thought can bring on the emotions: anger, sadness, love and fear? Write any suggestions up on the board as well as those listed below.

***Prompting events or thoughts** for anger*

Losing power.
Losing status.
Losing respect.
Being insulted.
Not having things turn out the way you expected.
Experiencing physical pain.
Experiencing emotional pain.
Being threatened with physical or emotional pain by someone or something.
Having an important or pleasurable activity interrupted, postponed, or stopped.
Not obtaining something you want (which another person has).
Expecting pain.
Feeling that you have been treated unfairly.
Believing that things should be different.
Rigidly thinking "I'm right".
Judging that the situation is illegitimate, wrong, or unfair.
Ruminating about the event that set off the anger in the first place or in the past.

***Prompting events of thoughts** for feeling sadness*

Things turning out badly.
Getting what you don't want.
Not getting what you want and believe you need in life; thinking about what you have not gotten that you wanted or needed.
Not getting what you have worked for.

Things being worse than you expected.

The death of someone you love; thinking about deaths of people you love.

Losing a relationship; thinking about losses.

Being separated from someone you care for or value; thinking about how much you miss someone.

Being rejected or excluded.

Being disapproved of or disliked; not being valued by people you care about.

Discovering someone else who is sad, hurt or in pain.

Reading about other people's problems or troubles in the world.

Believing that a separation from someone will last for a long time or will never end.

Believing that you are worthless or not valuable.

Believing that you will not get what you want or need in your life.

Hopeless beliefs.

Prompting events or thoughts *for feeling fear*

Being in a new or unfamiliar situation.

Being alone (e.g., walking alone, being home alone, living alone).

Being in the dark.

Being in a situation where you have been threatened or gotten hurt in the past, or where painful things have happened.

Being in a situation where you have seen other people be threatened, get hurt, or have something painful happen.

Believing that someone might reject you, criticize, dislike, or disapprove of you.

Believing that failure is possible; expecting to fail.

Believing that you might lose help and assistance you already have.

Believing that you might lose someone or something you want.

Losing a sense of control; believing that you are helpless.

Losing a sense of mastery or competence.

Believing that you might be hurt or harmed, or that you might lose something valuable.

Believing that you might die, or that you are going to die.

Prompting events or thoughts *for feelings of love*

A person offers or gives you something you want, need, or desire.

A person does things you want or need the person to do.

You spend a lot of time with a person.
You share a special experience together with a person.
You have exceptionally good communication with a person.
Believing that a person loves, needs, or appreciates you.
Thinking a person is physically attractive.
Judging a person's personality as wonderful, pleasing, or attractive.
Believing that a person can be counted on, will always be there for you.

I'm going to give you handouts with this information on it about how a certain emotion fear and events that may prompt a certain emotion. You can add your own suggestions if you wish. For your homework I want you to take every opportunity to recognise your emotions. If you are having any difficulty doing so think about what may have prompted you to feel this way. If you are going to binge, stop and decide what it is you are really feeling. Also continue with your monitoring.

Next week we will be doing a relaxation technique so you should wear comfortable clothes, and bring a towel and a pillow. If anyone wears contacts you may want to wear glasses next week.

Homework ; monitoring and recognising emotions.

SESSION 4

Get into pairs and talk about homework. Go around and talk to everyone.
Discuss as a class any difficulties, successes, etc, with homework.

For the most part the next four sessions will be teaching you some effective ways that you can manage your emotions. Today I'm going to teach you a relaxation technique. This process, if you practice regularly, can help you become relaxed. The relaxation benefits you derive can help you soothe yourself from some form of emotional distress, such as anger or stress, anxiety, sleeplessness.

First I want to go over the rationale of the procedure.

It was first developed in the 1930s by a physiologist named Jacobson and in recent years we have modified his original technique in order to make it simpler and more effective. Basically, progressive relaxation training consists of learning to sequentially tense and then relax various groups of muscles all through the body, while at the same time paying very close and careful attention to the feelings associated with both tension and relaxation. That is, in addition to teaching you how to relax you will learn to recognize and pinpoint tension and relaxation as they appear in everyday situations as well as in our sessions here.

It is very important that you realize that progressive relaxation training involves learning on your part. There is nothing magical about the procedures. I will not be doing anything to you, I will merely be introducing you to the technique and directing your attention to various aspects of it, such as the presence of certain feelings in the muscles. Thus, without your active cooperation and regular practising of these things you will learn today, the procedures are of little use.

You may be wondering why, if we want to produce relaxation, we start off by producing tension. The reason is that, first of all, everyone is always at some level of tension during their waking hours. If a person were not tense to some extent, they would simply fall down. The amount of tension actually present in everyday life differs, of course, from individual to individual and we say that each person has reached some adaptation level - the amount of tension under which they operate day to day.

The goal of progressive relaxation training is to help you learn to reduce muscle tension in your body far below your adaptation level at any time you wish to do so. In order to accomplish this, I could ask you to focus your attention, for example, on the muscles in your right hand and lower arm and to then just let them relax. Now you might think you can let these muscles drop down below their adaptation level just by letting them go, or whatever, and to a certain extent you probably can. However, in progressive relaxation, for much more noticeable reductions in tension, and the best way to do this is first to produce a good deal of tension in the muscle group, and then, all at once, release that tension. The release creates a momentum which allows the muscles to drop well below adaptation level.

Another important advantage to creating and releasing tension is that it will give you a good chance to focus your attention upon and become clearly aware of what tension really feels like in each of the various groups of muscles we will be dealing with today. In addition the tensing procedure will make a vivid contrast between tension and relaxation and will give you an excellent opportunity to directly compare the two and appreciate the difference in feeling associated with each of these states.

Muscle relaxation is a skill. The process of learning will be gradual and will require regular practice. Some discomfort may occur during the relaxation process. If so, just move your body to a more comfortable position. Also you may experience some floating, warming, or heavy sensations which is typical for some people learning muscle relaxation. If you find your mind wandering simply return to the exercise and carry on. *Check if anyone suffers chronic pain in any of their muscle groups. Those wearing contacts and glasses may want to take them off.*

Model relaxation exercise

I will model briefly a few of the muscle relaxation exercises that will be used in training, tell the group that the demonstration is going at a much faster rate than the speed at which they will perform the exercises. I will demonstrate with comments like "when I clench my biceps like this I feel the tension in my bicep muscles, and now when I relax and drop my arms to my side, I notice the difference between the tension that was in my biceps and the relative relaxation I feel now".

Another very important point to remember is that I will expect you to release the tension that you build up in these muscle groups immediately upon my cue. Please don't let the tension dissipate gradually. When I ask you to relax I would like you to completely and immediately release all the tension that's present in the right hand and lower arm. Do not gradually open the hand. Let all the tension go at the same time.

17 Muscle groups

Do a pre-training rating of overall tension on 1-10 scale on the board. Get everyone to lie on the floor with their towels and pillows. Now get as comfortable as you can, close your eyes and listen to what I'm going to tell you. I'm going to make you aware of

certain sensations in your body and then show you how you can reduce these sensations to increase feelings of relaxation. Remember to continue to breathe normally.

First, think about your right arm, your right hand in particular. Clench your right fist. Clench it tightly and study the tension in the hand and in the forearm. Study those sensations of tension. (Pause) Now let go. Just relax the right hand and let it rest. (Pause). And note the difference between the tension and the relaxation. (10 - second pause).

Now we'll do the same with your left hand. Clench your left fist. Notice the tension (5-second pause) and now relax. Enjoy the difference between the tension and the relaxation. (10-second pause).

Now bend both hands back at the wrists so that you tense the muscles in the back of the hand and in the forearm. Point your fingers toward the ceiling. Study the tension, and now relax. (Pause). Study the difference between tension and relaxation. (10-second pause.)

Now clench both your hands into fists and bring them toward your shoulders. As you bring them toward your shoulders tighten your biceps muscles, the ones in the upper part of your arm. Feel the tension in these muscles. (Pause.) Now relax. Let your arms drop down to your sides. See the difference between the tension and the relaxation. (10-second pause).

Now we'll work on relaxing the various muscles of the face. First, wrinkle up your forehead and brow. Do this until you feel your brow furrow. (Pause.) Now relax. Smooth out the forehead. Let it loosen up. (10-second pause).

Now close your eyes tightly. Can you feel tension all around your eyes? (5-second pause.) Now relax those muscles, noting the difference between the tension and the relaxation. (10-second pause.)

Now clench your jaws by biting your teeth together. Pull the corners of your mouth back. Study the tension in the jaws. (5-second pause.) Relax your jaws now. Can you tell the difference between tension and relaxation in your jaw area? (10-second pause.)

Now press your lips together tightly. As you do this, notice the tension all around the mouth. (Pause.) Now relax those muscles around the mouth. Enjoy this relaxation in your mouth area and your entire face. (Pause.)

Now we'll move to the neck muscles. Press your head back. Can you feel the tension in the back of your neck and in your upper back? Hold the tension. (Pause.) Now let your head rest comfortably. Notice the difference. Keep relaxing. (Pause).

Now continue to concentrate on the neck area. Bring your head forward. See if you can bury your chin into your chest. Note the tension in the front of your neck. Now relax and let go. (10-second pause.)

Now we'll move to the shoulder area. Shrug your shoulders. Bring them up to your ears. Feel and hold the tension in your shoulders. (Pause). Now, let both shoulders relax. Note the contrast between the tension and the relaxation that's now in your shoulders. (10-second pause.)

Now direct your attention to your upper back area. Arch your back gently like you're sticking our your chest and stomach. Can you feel tension in your back? Study that tension. (Pause.) Now relax. Note the difference between the tension and the relaxation. (10-second pause).

Now take a deep breath, filling your lungs, and hold it. Feel the tension all through your chest and into your stomach area. Hold that tension. (Pause.) Now relax and let it go. Let your breathe out naturally. Enjoy the pleasant sensations. (10-second pause.)
An alternative instruction is to tell the client to pull in your stomach or suck in your stomach.

I'd like you now to focus on your legs. Stretch both legs. Feel tension in the thighs. (5-second pause). Now relax. Study the difference again between tension in the thighs and the relaxation you feel now. (10-second pause).

Now concentrate on your lower legs and feet. Tighten both calf muscles by pointing your toes toward your head. Pretend a string is pulling your toes up. Can you feel the pulling and the tension? Note that tension. (Pause). Now relax. Let your legs relax deeply. Enjoy the difference between tension and relaxation. (10-second pause.)

After each muscle group has been tensed and relaxed twice:

Now, I'm going to go over once more the muscle groups that we've covered. As I name each group, try to notice whether there is any tension in those muscles. If there is any, try to concentrate on those muscles and tell them to relax. Think of draining the tension completely out of your body as we do this. Now relax the muscles in your feet, ankles, and calves. (Pause.) Get rid of tension in your knees and thighs. (5-second pause.) Loosen your hips (Pause.) Let the muscles of your lower body go. (Pause.) Relax your abdomen, waist, lower back. (Pause.) Drain the tension from your upper back, chest, and shoulders. (Pause.) Relax your upper your upper arms, forearms, and hands. Loosen the muscles of your throat and neck. (Pause.) Relax your face. (Pause). Let all the tension drain out of your body. (Pause.) Now just sit quietly with your eyes closed.

I'm going to count from 5 to 1. When I reach the count of 1, open your eyes. 5, 4, 3, 2, 1. Open your eyes now.

Post-training Assessment
Rate tension on 1-10 scale - compare with pre-training level.
What is your reaction to the procedure?
How do you feel?
What reaction did you have when you focused on the tension?
What about relaxation?
How did the contrast feel between the tension and relaxation feel?
Encourage performance etc.
What kind of situation do you think you could use this technique?

Talk about these issues with the group – especially the last one in terms of emotional distress.

Possible problems to be aware of

Cramps - possibly too much tension being created in the particular muscle group, so instruct them to decrease amount of tension.

Spasms and tics - these are common when one's asleep, and possibly the reason that the client is aware of them now is that he or she is awake.

Falling asleep - continually falling asleep can impede learning the skills associated with muscle relaxation.

Occurrence of unfamiliar sensations such as floating, warmth and headiness. Point out that these sensations are common and they should not fear them.

Relaxation training, like learning any skill require a great deal of practice. The more you practice the procedure, the more proficient you will become in gaining control over tension, anxiety, or stress.

It is a good idea to select a quiet place for practice. Free from distracting noise. Do a pre- and post-test of your tension levels. You should practise the muscle relaxation exercise about 15 to 20 minutes once a day. They should be done when there is no time pressure. They can be done in a recliner chair, in bed or on the floor with a pillow supporting the head as we have done today.

Homework for this week is to continue with your monitoring and recognising emotions and to practice this relaxation technique everyday as we will be doing a shorter version on this next week.

Next week we will also be looking at problem-solving and do a writing task.

SESSION 5

Review homework – monitoring, recognising emotions, relaxation.

Problem-solving skills

While many problems feel overwhelming at first, if they are approached systematically they usually turn out to be manageable. Training in problem solving helps you tackle day-to-day difficulties. When a problem arises causing a negative emotion, it may be common for you to block the emotion by bingeing as an escape, which results in no solution. If you learn to use the problem-solving technique effectively, it will further reduce your vulnerability to binge by improving your ability to cope with situations that would previously have brought on negative emotions that would previously have triggered episodes of overeating.

Efficient problem solving follows these commonsense steps.
The problem should be identified and specified as soon as possible after it has occurred. It may emerge that there are two or more coexisting problems, in which case each should be addressed separately. Break the problem into manageable tasks -rephrasing the problem is often helpful. All ways of dealing with the problem should be considered. You should brainstorm and generate as many potential solutions as possible. Some solutions may immediately seem nonsensical or impractical. Nevertheless, they should be included in the list of possible alternatives. The first solution is not always the best and the more solutions that are generated the more likely a good one will emerge. The likely effectiveness and feasibility of each solution should be considered. One alternative should be chosen. This is often an intuitive process. Sometimes a combination of solutions is best. The steps required to carry out the chosen solutions should be defined. The solution should be acted upon. The entire problem-solving process should be evaluated the following day in the light of subsequent events. This is a crucial step, since the goal is not simply to resolve the specific problem in question. Rather it is to become skilled at problem solving. You should therefore review each of the steps for problem solving and consider how the entire process could have been improved.

Look at problem-solving as a 7-step process. (write these steps up on the board)

1. Problem recognition.
2. Problem definition.
3. Generation of alternative solutions. Brainstorming.
4. Evaluation of alternative solutions.
5. Making a decision.
6. Implementation of the solution.
7. Verification of the solution's effect.

Generate a problem in class and go through the steps with everyone. Get everyone to think of a problem that they are facing now and get them to go though the steps by themselves. Make sure everyone understands what they are doing.

Self-regulation writing task

It is widely acknowledged in our culture that putting upsetting experiences into words can be healthy. Research from several domains indicates that talking with friends, confiding in a therapist, praying, and keeping a diary of one's thoughts and feelings can all be beneficial. *How many of you use at least one of these as a type of 'sounding board'?*

Writing itself is a powerful therapeutic technique where people are able to guide their own therapy. Self-regulation writing allows you to explore your thoughts and feelings about stressful experiences, and helps you focus on selecting, enacting, and appraising specific ways to cope with these problems. It can facilitate adjustment to stressful events by integrating beliefs, emotions, and experiences so that you can better make sense of the events and identify ways to cope with them. In short self-regulation writing focuses the writer on problematic aspects of personal events and then forming and appraising coping strategies.

We will be doing this task over three sessions. Today I want you to let go and write for 15 minutes about your very deepest thoughts and feelings about a recent event that has been emotionally unsetting for you. In the last 5 minutes list three things that you can do that will help you deal with one or more of these problems and challenges. Write down

your coping plans on the reminder slip provided. Take it home with you and bring it back next week.

Relaxation for four muscle groups.

Pre-tension rating to be taken.
Now get as comfortable as you can, close your eyes and listen to what I'm going to tell you.

First think of the muscles in both your arms in the hands and biceps. Clench these muscles tightly. Clench them tightly and study the tension in your hands in the forearm and in your biceps. Study those sensations of tension. (Pause) Now let go. Just relax the muscles and let your arms rest. (Pause). And note the difference between the tension and the relaxation. (10 - second pause).

Now we'll work on relaxing the various muscles of the face and the neck.
Clench your eyes, your jaw you lips, your neck. Clench them tightly and study the tension. (Pause). Now let go. Just relax the muscles. (Pause). Enjoy the difference. (10-second pause).

Now we'll move to your shoulder back, chest and stomach. Feel and hold the tension in these muscles. (Pause). Now let both shoulders back, chest and stomach relax. Note the contrast between the tension and the relaxation that's now in these muscles. Enjoy the pleasant sensations. (10-second pause.)

I'd like you now to focus on your upper legs, your calves and feet. Feel the tension in these muscles. (5-second pause). Now relax. Study the difference again between tension in these muscles and the relaxation you feel now. (10-second pause).

After each muscle group has been tensed and relaxed twice:

Now, I'm going to go over once more the muscle groups that we've covered. As I name each group, try to notice whether there is any tension in those muscles. If there is any, try to concentrate on those muscles and tell them to relax. Think of draining the tension

completely out of your body as we do this. Now relax the muscles in your feet, ankles, and calves and upper legs. (5-second pause). Let the muscles of your lower body go. (Pause.) Drain the tension from your stomach, your chest and back. (Pause.) Relax your upper arms, forearms, and hands. Loosen the muscles of your throat and neck. (Pause.) Relax your face (Pause). Let all the tension drain out of your body. (Pause.) Now just sit quietly with your eyes closed.

I'm going to count from 5 to 1. When I reach the count of 1, open your eyes. 5, 4, 3, 2, 1. Open your eyes now.

Post-tension rating to be taken.

Homework

Practice recognising your emotions, relaxation, problem solving, and continue to monitor your eating and emotions. Remember to bring back your slips with your coping strategies.

Next week we will be doing some more writing and some assertiveness training.

SESSION 6

Greetings etc.

Review homework – problems, successes. (monitoring, recognising emotions, relaxation, problem-solving skills)

I want you to get out your reminder slips with your coping strategies from last week on them. I want you yet again to write for 15 minutes about your deepest thoughts and feelings about the same recent event that was emotionally upsetting to. In the last 5 minutes I want you to list the coping actions identified in the previous session and indicate for each one (a) did you try it?; (b) if you did try it, to what extent was it helpful; and (c) if you have not tried it, why not? Now list three actions for dealing with...they can be the same as or different from those listed in our last session. Write these on the reminder slip provided and bring it back again next week.

Assertion training

Being assertive is essentially about respecting yourself and others. It is about having a basic belief that your opinions, beliefs, thoughts and feelings are as important as anybody

else's - and that this goes for other people too. It is about being in touch with your own needs and wants, but it is not about going for what you want at any cost.

To be assertive is to be able to express yourself clearly, directly and appropriately, to value what you think and feel, to have esteem and respect yourself: to recognise your own strengths and limitations. In other words, to appreciate yourself for who you are. Communicating assertively means telling the truth, from a position of accurate self-perception. Why are we sometimes reluctant even to tell ourselves the truth about what we are thinking or feeling? To avoid fearful, negative emotions as they are too painful, and largely because we often do not accept our own thoughts and feelings.

Being assertive also means taking responsibility for your life and your choices. It means making your own decisions, rather than simply drifting or going along with other people's choices. It means not blaming other people or circumstances for what happens to you. If you take responsibility for your own life, you can change the parts that are not as you want them. If you blame the outside circumstances for you life, it means you are helpless to change it.

Learning to be assertive in your behaviour implies that you have the right to practice this behaviour. Assertive rights are basic human rights. To be assertive you need to believe that you have the right to be assertive. When you learn about being assertive, you learn more about yourself, you become more self-aware, because you begin to look at your present behaviour and begin to consider ways of changing it where you want to.

Being **non-assertive** means you don't respect your own right to express your ideas, needs, wants, feelings and opinions. If you are non-assertive, you might be able to avoid a conflict in the short term, but since no one knows how you feel you probably won't get what you want or need. In addition, you may feel as though no one respects you or get angry with other people for taking advantage of you.

Being **aggressive** means saying what you feel in a way that disregards another person's right to be respected. If you are aggressive you may get what you want because others are afraid not to give it to you, but you may also wind up turning people off or feeling guilty for acting that way.

Being **assertive** means that you honestly state your feelings without denying your own right to express yourself (non-assertive) or denying the rights of others to be respected (aggression). If you are assertive, you let people know what you think, so you have a good chance of getting what you want and need. In addition, you avoid feelings of resentment, anger, and guilt and because you show respect for other people, you don't wind up turning them off.

A first step in making any changes we want to make in our behaviour is to be aware of how we behave now.

Here is an exercise which will help you to identify messages you give to yourself. Get into pairs and each of you...

1. Remember a situation or incident in the past, which did not go well for you.
2. Recall what you were telling yourself while this situation was happening. Write it down.
3. Evaluate it. Ask yourself, not whether what you were telling yourself was 'right', but rather was what you were telling yourself helping you in that situation. Was it helping?

-your feelings
-your level of stress
-your self-esteem
-your behaviour
-your relationships

4 If it was not helping you, why were you saying it? *At this point your partner is going to come up with an alternative message for you.* Find an alternative message which would be helpful (the opposite of what you were saying). So if you were saying "I'm not going to be able to do this" an alternative message might be "I accomplish this task with ease and confidence."

5 Next time you are in a similar circumstance, say the positive message to yourself.

Pairs will present their situations and alternative messages to the group.

Self-talk - attitudes and beliefs about oneself are typically most obvious in the specific sentences people use when they talk to themselves. For example if a student did poorly

on an exam they might say something to themselves such as "I did poorly on this exam. I am so dumb". Irrational beliefs in self-talk such as this one are without foundation. They are simply acquired beliefs that are best disregarded. This type of self-talk is a psychological trigger that activates useless negative feelings that eventually come to serve as inhibitors to human behaviour and performance. Self-talk is associated with assertiveness problems and assertiveness training in several ways. The two major types of interpersonal problems that assertiveness training is designed to change are the non-assertive behaviour and aggressive behaviour that I mentioned earlier. Both are caused by a certain kind of self-talk (and this self-talk is generally negative or irrational).

Let's look at some examples.

A non-assertive example

A. Recurring event: Sarah frequently felt during discussions in her university classes that she had something to add to the subjects being discussed, but never expressed her views.
B. Self-talk: I'm afraid that I may not be able to get my thoughts across as I may get stage fright and lose my train of thought.
My voice may crack from anxiety and the class will then laugh at me.
I'm already beginning to perspire from thinking about talking in a class- why should I take the risk?
I may think what I have to say is important, but will the others?
It would be awful if they didn't.
What if somebody asks me a question about what I have to say?
If I can't answer it, I'll really look like a dummy.
C. Emotion: Anxiety and a deeply uncomfortable feeling about herself due to the conflictive thoughts of wanting to express his views while fearing the consequences.
D. Action: Continuing to sit in her classes without expressing her views.

An aggressive example.

A. Event: While Karen is walking to her car in a parking lot at a shopping mall, she sees another car run into hers.

B Self-talk: That stupid driver has no right to do this to me.
What if this driver doesn't have insurance, and tries to get out of paying?

I'll loss my no-claims bonus without me even doing anything wrong – this is awful.
What a hassle this is going to be – reporting it to the police, paying for the repairs, finding a panel beater to repair the damage, getting around while the car is being repaired.
My beautiful car will never look the same because of this idiot driver.
I've been seriously wronged, and I intend to get even. I'm going to tell that driver exactly what I think. Furthermore since this driver hit me, I have a right to hit back.

B. Emotion: Intense anger.
C. Action: Yelling (including obscenities at the driver) and slapping the driver in the face.

Since self-talk causes non-assertive or aggressive behaviour, it follows that it is necessary to change the self-talk in order to enable people to become more assertive. People first become assertive when they tell themselves that they have the right to be themselves, and that they can and will express their thoughts freely.

Instead
I am able to talk in class without my voice cracking, and without students laughing at me. Getting answers to the questions I have will help me on exams, and also help me to get more out of these courses. I'm making progress in becoming assertive and being able to express myself. The next thing I will try is expressing a view that I have.
Some anxiety, but increased pride in self from being able to begin expressing self.
Beginning to express her views in class.

Assertion and anger

It is quite normal to feel angry or irritated or frustrated. It is difficult to be human and live in the world without feeling these emotions sometimes. The emotion of anger tends to be a particularly strong one, and I think it is important that we take a look at how it operates in our lives. If we know more about it then we can take steps towards dealing with it productively and assertively.

Most of us find anger difficult to deal with because we experience it as a very strong emotion. In western societies in particular, expressing emotions is not very acceptable, so we often may feel guilty and uncomfortable about expressing them at all - especially anger and especially for women. *How do men and women express their anger?* Often we deny even feeling angry. It seems easier, sometimes, than coping with the hassle of working out what to do with it. But is it really easier in the end? Have you ever suppressed or denied your anger at the time of feeling it, only to have it erupt inappropriately in a completely different situation? We are not saying it is always appropriate to express anger, but, as with other feelings, it is always a good idea to tell yourself the truth about what you are feeling, to acknowledge it.

When are some times that we get angry?

Broadly the times when we get angry can be categorised as follows:

1. When we feel thwarted, threatened or disrespected in some way; when the path towards our chosen goals has seemingly been blocked by someone else's action.
2. As a defence, when really we are desperately hurt, but do not want to appear vulnerable, so we show anger instead.
3. When a situation or action by someone else has triggered off memories of a hurtful, damaging, or unresolved situation in our past.
4. When we feel our rights have been violated, or someone has 'done us wrong'.
5. When we are frightened or feeling inadequate in some way, and feel angry with ourselves.

Angry Feelings

We do feel angry sometimes, but few of us know what to do with these feelings. To understand why this is so, and in order to explore where anger comes from, let us look briefly at some of the feelings which may accompany anger. List these on the board.

Self-righteousness

When we are angry about something we tend to believe ourselves to be in the right - and the other person wrong. A question to ask yourself in these circumstances is - is that true? If we have believed this and then choose to say we are angry, it is likely to emerge

in an aggressive and accusatory manner. Ask yourself, do you want to punish the other person?

Indignation

The 'how dare they?' syndrome. If you experience even a smattering of this feeling, it could be that you are taking yourself too seriously or taking what someone does far more personally than is good for you. For example, if a friend has promised to telephone by Monday to tell you whether she will be able to help with the party, and it is now Wednesday and she still has not telephoned - if this makes you feel angry and indignant, stop to consider whether it may be other things going on in her life that have prevented her from telephoning, rather than that she has no respect for you. This will not make the anger go away, but it will put it in perspective.

Low self-esteem

Much has been said about this, and ways of dealing with it. The truth is that if we feel badly about ourselves, we are more likely to take things personally, to regard someone's action as a personal attack or insult, when that was not intended.

Judging

This is closely linked with the previous three and particularly with self-righteousness. Someone has done something that we do not agree with and therefore 'she must be wrong'. This is the way the thinking tends to go if you are being judgemental: 'he must be pretty stupid anyway', and so on.

What tends to happen if we have any of these thoughts and feelings, of course, is that they come out when we speak to the individuals concerned. Few people are able to express angry feelings clearly and directly.

Is anger useful? How? List these on the board.

Positive action

As we have already discussed in early sessions, all emotional distress is a reminder that all is not as we want it to be in our world. Dissatisfaction is a positive thing. Without it, we would simply put up with life as it is and not take any action to further out goals. For

example if women early this century had not felt angry at their disenfranchisement, they would not have fought for the vote.

Releasing stress

Expressing anger can be a great stress-releaser: feelings which might otherwise get suppressed and cause distress or even illness may be released. This does not mean it is necessary to express it to the person we think we feel angry with.

Increased openness

It can lead to increased openness in relationships and an increased trust. There is a feeling of respect engendered if you know someone is willing to talk to you about the more difficult areas, not just skim over them as if they did not exist.

Unblocking feelings

If we are in touch with out feelings, including anger, as they occur, and deal with them appropriately, we then stand less chance of creating a backlog of unexpressed or blocked feelings, which can lead to internal stress and serious miscommunication.

Achieving objectives

Importantly, the energy contained in the emotion of anger has the same quality as that which pushes us to do things to further our goals. Used correctly, it can assist us in being assertive and expressing ourselves and going for what we want in life. But it must be carefully handled.

Anger can be a very destructive emotion

1 Anger can lead to bad power conflicts with both parties maintaining the rightness of their viewpoints.

2 When expressing anger, it is easy to trigger past unresolved or unexpressed anger, and thus 'go over the top'.

3 Following for the above, the recipient may misunderstand and there may be confusion

4 Anger can lead to irrational or confused thought. We can become obsessed at 'righting the wrong' that has been done to us and focus disproportionately on the past injustice rather than on the present.

How non-assertive anger expression escalates
Some of the signs of hidden anger

It is assertive to acknowledge anger - or any other feeling, if you are experiencing it. But sometimes you do not actually realise that what you are feeling is anger. You know there is 'something wrong', but cannot pinpoint what it is. These are some of the signs:

1. Overeating, drinking too much or inexplicable body pains can be signs that you are angry, and turning the anger in on yourself.
2. Anger may well be operating if you find yourself getting irritated easily, for example when driving or going about ordinary daily activity; if you are finding any excuse to create a conflict; or rather than telling someone something in a direct manner, you get back in subtle ways.
3. If you find you are blaming other people a lot, or feeling you must get away from it all, or feeling hurt or victimized, you may in fact be feeling angry with something quite unconnected with that situation.
4. Internalized anger can, in fact, lead to (severe) depression. Ignoring the fact that you are feeling angry can quite literally make you ill.

For homework practice recognising your emotions, relaxation, problem solving, and continue to monitor your eating and emotions. Remember to bring back your slips with your coping strategies.

Next week will be similar to today's session but in addition we will be doing some role-playing of scenarios that will involve assertion.

SESSION 7

Review homework. - problems/successes (monitoring, recognising emotions, relaxatioon, problem-solving skills)

<u>Making requests</u>

Present experience. E.g., I'd like to ask her or him for this or that. But I can't. Why can't I? *What reasons do people come up with?*

1. They might say 'no': I might fail to get what I want.
2. They might say 'yes': do I really want it after all?
3. I might feel rejected if they refuse my request.
4. They might think badly of me for asking this of them.
5. If I ask, they will think that I cannot cope.
6. If I ask, I will make myself vulnerable.

Here is an exercise to enable you to find out how you may feel about making requests.

1. When you are tempted not to ask, do you give yourself similar reason to the above?
2. What other reasons do you give yourself for not asking for what you want?
3. Ask yourself the following questions about these reasons:

- is what you are telling yourself likely to be true?
- how much does it matter to you?

Now let us look at some of the possibilities

They might say 'NO' : I might fail to get what I want.

Yes, of course this might happen. We all have the right to say no. You may feel disappointed that you have not got what you want. What else do you feel? When we ask people this, the most common response is "I feel I've failed'. Now this statement is ambiguous. You have indeed failed, at least for the present, to obtain what you want, but that is all. You have behaved assertively in asking and giving yourself your best chance of succeeding. In this aspect you have succeeded, not failed. Fear of failure is one of the commonest reasons for not asking. It depends on what you choose 'failure' to mean.

They might say 'Yes' : do I really want it after all?

The question to ask yourself is: "Do I really want what I am asking for?" This is a very important question and it is unhelpful to mix it up with the different questions, "will I get it?" or "am I worth it?" The best idea is to make up your mind about what it is you want first. You may not be absolutely certain what it is you want, but at least be clear what it is you are asking. Do not pretend that you really want whatever the other person chooses

to give you. Is it so dreadful to succeed both in being assertive and in getting what you want? The answer to this may be 'yes' if you fear success. This fear of success is much more common than may be realized in our success-oriented culture. It is important to define what success means to you. For example, if success means taking action to support being true to yourself, then it will be important to ask if you want to ask.

I might feel rejected if they refuse my request

It is important to distinguish between being rejected as a person and having your request rejected. Many of us feel rejected easily because of negative childhood experiences. You have the right to ask. You do not have the right to expect the other person to say yes.

They might think badly of me for asking this of them.

They might. But it is important to be in touch with your own assessment of yourself, rather than emphasizing someone else's opinion of you, which, in fact, probably says more about them than about you. If someone, for example, your boss, has the power to give your what you want, clearly his or her opinion is important, as this will influence whether or not you get it. However, you can still aim to make an accurate self-assessment - is it more important to ask, or is it more important to have someone else's approval?

If I ask, they will think that I cannot cope

Well, maybe you do have more to do than you can handle at that particular time. That is not terrible. It is important to acknowledge when we need help. Often people feel very happy to be asked.

If I ask, I will make myself vulnerable, perhaps powerless.

You make yourself vulnerable by asking only if you are dependent on the person to reply in one particular way. Under certain circumstances you are in fact very dependent on another person. If you are lost in a desert and dying of thirst then you would be dependent on your friend who has a full water bottle. Most of our life does not involve such extreme physical dependence; our emotional dependence is something we can learn to change.

<u>Saying yes and saying no</u>

Saying yes and no are important responses which an assertive person needs to be able to make. They are important ways we have of defining ourselves and showing other people how we wish to be treated and where our boundaries are. They are not the only assertive responses that we may wish to make in a particular situation. We're going to look at using no assertively.

Not saying no when you want to means that you are placing more importance on the other persons needs than on your own. You are failing to draw boundaries. It can create future problems and it is better to be honest in the first place. Would you prefer it if someone said no to you when that was what they meant rather than yes. Would you prefer them to be honest with you?
Why is it difficult to say 'no'?

What stops you from saying no in any particular situation? Let us look as some of the major reasons.

If I say no, they may feel hurt or rejected.
This of course is impossible. If you say no to a particular request the other person may feel rejected as a person. But you cannot be responsible for someone else's feelings; you can be responsible only for yourself. If you know this person feels easily rejected, you can say, 'I don't want you to feel bad or rejected, but...' and then add your statement. This shows that you are taking this person's feelings into account-but not holding yourself responsible for them. It is patronizing to think we can be in charge of other people's feelings.

If I say no this time, they may not like me any more.
Ask yourself - is this really likely. And if it is, do you really want such a person as a friend anyway, if they do not respect your right to say no?

If I say no this time, they may never ask again.
This too, is possible - but irrelevant. You can deal only with one situation at a time. You cannot control or predict how someone else is going to act in the future. Besides it is

always possible to say 'Do ask me another time' to make it clear you are saying no then, but not necessarily for always.

They won't take any notice if I say no.

You do not absolutely know this, although your past experience with this person may tell you that this is very likely. Even if they do not, at least you will have taken the step of setting your boundaries. So you will have succeeded in the first stage of being assertive.

They'd say yes to me (and so I'll feel guilty if I refuse them).

This is another instance of getting two situations confused. What you do is your responsibility; what they do is theirs. Feeling guilty is largely a habit and, to our knowledge, no good ever came of it. As you practice being assertive, the guilty feelings will lessen over time.

I can't say no because I feel sorry for them.

If I say no, perhaps no one will be able or willing to help them out, and so, they will be stuck. If you need to say no for whatever reason, for example other commitments you have, saying yes and putting yourself under pressure will only make you feel angry with yourself and resentful towards the other person. At worst, it may mark the friendship.

Do not forget that it is always possible to change a previous arrangement, and say yes to the person making the request; the key question is whether you say yes from choice or from a sense of duty or obligation. If the latter, once again you will tend to feel resentful and, perhaps, blaming towards the other person.

How to say 'No' assertively

1. Start your reply with a clear, firm, audible 'No'.
2. Do not justify or make excuses. Giving a reason is different from over-apologizing.
3. Feel that you have a right to say 'no'.
4. Once you have said 'no', do not stay around waiting to be persuaded to change your mind. Make a definite closure by changing the subject, walking away, continuing with what you were doing - whatever is appropriate.
5. Remember you are saying no to that particular request, not rejecting the person.
6. If the request takes you unawares or you have not sufficient time to think when asked, you can always say. "I'll let you know" in order to give yourself time to think about what you want to say.

7. Take responsibility for saying no - do not blame the other person for asking you.
8. Ask for more information if you need it in order to decide whether you want to say yes or no.

Here are some common situations that arise where assertion is required.

1. Expressing disapproval and annoyance. At times, an undesirable situation is concluded, or cannot be changed. Nevertheless, it is often appropriate to express discontent. Such communication may prevent future mistreatment. Also, unexpressed annoyance can have a variety of maladaptive consequences, not the least of which is depression. The goal of training is to facilitate productive complaints rather than an angry outburst or passive-aggressive bitching. An appropriate response contains (a) an "I" statement followed by (b) a description of the stimulus, and (c) a request or suggestion for future behaviour (e.g., "I'm really angry at you. I told you I was planning a special meal. If you can't be on time, call me so I know in advance").

2. Requesting new behaviour from others. Standing up for one's rights often entails getting other people to change their unacceptable behaviour. Here again, an "I" statement followed by a reason is effective: "I really can't concentrate with the TV so loud. Please turn it down a little!"

3. Refusing unreasonable requests. This is the most basic task in resisting mistreatment by others. It is most effectively accomplished by a clear, yet sympathetic statement, coupled with an explanation (e.g., I'm sorry, but I just can't help you out. I have another appointment and have to leave").

4. Compromise and negotiation. Being "assertive" does not require always getting one's own way. Frequently, reinforcement is maximized by cooperation and compromise. The task here involves (a) stating one's feelings or desires, and (b) reflecting the partner's feelings or desires, and (c) suggesting a mutually acceptable resolution: "I

know you want to go to the movies, but I'm trying to save my money. How about if we get out a video. That way I won't spend so much money".

5. Offering an apology, (1) make an "I" statement of regret (e.g. "I'm really sorry!"), (2) give an explanation (e.g., "I didn't know you would be coming"), and (3) comment on the person's feelings or discomfort (e.g., "I hope you didn't have too much trouble").

You're going to be working in pairs again. I have several scenarios in this box. Draw out one each. Help each other come up with an assertive response for your scenarios. We will go around everyone and after reading out your scenario to us, you must demonstrate an assertive response to your partner. Give each person plenty of feedback.

The next thing we need to work on is eye contact. It is important that you look straight at people when you are being assertive, telling them that you are displeased. If you do, they'll know you are serious and you will not be taken lightly. If you don't, they'll think that you are unsure of yourself and can be bullied.

I want you to do your scenario again and this time make sure you are looking at their face for the entire time you speak. You don't need to look directly at their eyes. Let your gaze shift slowly from their forehead to their nose, to their mouth, and back to their forehead. But keep looking at their face. Give feedback. Do more scenarios.

Now I want you to get out your reminder slips with your coping strategies from last week on them. *How many of you tried them out? Those of you that did, to what extent was it helpful? For those of you who did not try it, why not? So how many of you found this exercise a useful one?*

Applied relaxation

I want to talk about a technique where you can use progressive relaxation in everyday situations. Differential relaxation is one of the most common applications of the basic progressive relaxation skill. A variety of muscles become tensed during most behaviours. Muscles necessary for the accomplishment of an activity are frequently more tense than they need to be and muscles unnecessary for efficient performance become tense during the activity. In both cases, there is residual tension which contributes nothing to the behaviour and which needlessly increases psychological stress. Ideally, in terms of conservation of energy and maintenance of a low tension level, only those muscles

directly relevant to an activity should be tense only to the degree required for efficient performance of the activity.

The procedure essentially involves the periodic identification of tension during daily activities and the subsequent relaxation of muscles that are unnecessarily tense. Identification of tension is, of course, one of the skills that are learned during progressive relaxation training.

1. Sitting, non-active quiet place: e.g. sitting upright in a chair in a bedroom.
2. Sitting non-active, non-quiet place: e.g. sitting in a cafeteria.
3. Sitting active, quiet place: typing in a study.
4. Sitting, active, non-quiet place: e.g. eating in a cafeteria.
5. Standing, non-active, non-quiet place: e.g. standing in a living room.
6. Standing, non-active, non-quiet place: e.g. waiting in a ticket line.
7. Standing, active, quiet place: e.g. working alone at a counter.
8. Standing, active, non-quiet place: e.g. walking outside.

These steps involve increasing distracting as well as activity in more muscle groups. The procedure: first identify, then eliminate the tension in each non essential muscle group. There is no need to be concerned about residual tension in muscles required for performance of ongoing behaviour. You can progress though these steps at your own pace, but speed of progress is, of course, dependent upon the frequency and quality of practice.

Continue practising your emotion management techniques. Next week we will talk about maintaining your improvements.

SESSION 8

Maintenance

I want you all to consider how you will manage now that we have come to the end of this programme. Obviously you will not want to monitor indefinitely. When you wish to stop check your motives for doing so. The desire to stop may stem from a reluctance to acknowledge that there has been a deterioration in the eating problem.

It is important to ensure that you do not have unrealistic expectations for the future. Know that at times most people eat more than they think they should, and if you do so this is neither abnormal nor a sign that your control over eating is deteriorating. Expect occasional setbacks. Use the skills you have developed in this programme to deal with your emotions better. Review why setbacks occur and how you might prevent them from occurring again.

Set some time aside so that you can reflect on the current situation. You need to devise a plan of action. Re-evaluate your progress every day or so.

What elements of the programme did you find most helpful? Today you will prepare a written plan for dealing with times when you sense your eating is becoming a problem.

Maintenance plan

If your eating problem is getting worse or if you sense you are at risk of bingeing, the techniques that you found most helpful from the programme are listed below.

(Have them write their chosen techniques here).

At such times there will often be some underlying problem. You must therefore examine what is happening in your life and look for any events or difficulties that might be of relevance. If any problems seem relevant, you should consider all possible solutions in order to construct a plan of action. In addition, you should use one or more of the following strategies to address your eating.

Confine your eating to three planned meals each day, plus two planned snacks.

Plan your days ahead. Avoid both long periods of unstructured time and overbooking. If you are feeling at risk of losing control, plan your meals in detail so that you know exactly what and when you will be eating. In general, you should try to keep one step ahead of the problem.

Identify the times at which you are most likely to over-eat (from recent experience and the evidence provided by your monitoring sheets) and plan alternative activities that are not compatible with eating, such as meeting friends, exercising, or taking a bath.

If possible, confide in someone. Talk through your problem. A trouble shared is a trouble halved. Remember, you would not mind any friend of yours sharing his or her problems with you.

Set yourself limited realistic goals. Work from hour to hour. One failure does not justify a succession of failures. Note down any progress, however modest, on your monitoring sheets.

Questionnaires to be filled out.

Programme complete

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APPENDIX 2
QUESTIONNAIRES

Demographics Questionnaire

Name _____

Date of birth _____

Ethnicity (tick) Pakeha
Maori
Specify other_____

Relationship status (tick) Married/defacto
Always single
Single after previous marriage/defacto

Dependants (tick) No Yes (if yes – what gender/ages?) _____

Occupation _____

Highest completed education qualification _____

Approximate weight _____

Approximate height _____

Are you currently on a diet? (tick) Yes No

Are you currently receiving treatment for any psychological problem? (tick) Yes No

Instructions

Your ratings on the items below will be made on the EDI-2 answer sheet. The items ask about your attitudes, feelings, and behaviour. Some of the items relate to food or eating. Other items ask about your feelings about yourself.

For each item, decide if the item is true about you ALWAYS (A), USUALLY (U), OFTEN (0), SOMETIMES (S), RARELY (R) OR NEVER (N). Circle the letter that corresponds to your rating on the answer sheet. For example, if your rating for an item is OFTEN, you would circle the O for that item in the Answer Sheet. Respond to all the items, making sure that you circle the letter for the rating that is true about you. DO NOT ERASE! If you need to change an answer, make an "X" through the incorrect letter and then circle the correct one.

1. I eat sweets and carbohydrates without feeling nervous.
2. I think that my stomach is too big.
3. I wish that I could return to the security of childhood.
4. I eat when I am upset.
5. I stuff myself with food.
6. I wish that I could be younger.
7. I think about dieting.
8. I get frightened when my feelings are too strong.
9. I think that my thighs are too large.
10. I feel ineffective as a person.
11. I feel extremely guilty after overeating.
12. I think that my stomach is just the right size.
13. Only outstanding performance is good enough in my family.
14. The happiest time in life is when you are a child.
15. I am open about my feelings.
16. I am terrified of gaining weight.
17. I trust others.
18. I feel alone in the world.
19. I feel satisfied with the shape of my body.
20. I feel generally in control of things in my life.
21. I get confused about what emotion I am feeling.
22. I would rather be an adult than a child
23. I can communicate with others easily.
24. I wish I were someone else.
25. I exaggerate or magnify the importance of weight.
26. I can clearly identify what emotion I am feeling.
27. I feel inadequate.
28. I have gone on eating binges where I felt I could not stop.
29. As a child, I tried very hard to avoid disappointing my parents and teachers.
30. I have close relationships.
31. I like the shape of my buttocks.
32. I am preoccupied with the desire to be thinner.
33. I don't know what's going on inside of me.
34. I have trouble expressing my emotions to others.
35. The demands of adulthood are too great.
36. I hate being less than best at things.
37. I feel secure about myself.

38. I think about bingeing (overeating).
39. I feel happy that I am not a child anymore.
40. I get confused as to whether or not I am hungry.
41. I have a low opinion of myself.
42. I feel that I can achieve my standards.
43. My parents have expected excellence of me.
44. I worry that my feelings will get out of control.
45. I think my hips are too big.
46. I eat moderately in front of others and stuff myself when they are gone.
47. I feel bloated after eating a normal meal.
48. I feel that people are the happiest when they are children.
49. If I gain a pound, I worry that I will kept gaining.
50. I feel that I am a worthwhile person.
51. When I am upset, I don't know if I am sad, frightened, or angry.
52. I feel that I must do things perfectly or not do them at all.
53. I have thought of trying to vomit in order to lose weight.
54. I need to keep people at a certain distance (feel uncomfortable if someone tries to get too close).
55. I think that my thighs are just the right size.
56. I feel empty inside (emotionally).
57. I can talk about personal thoughts or feelings.
58. The best years of your life are when you become an adult.
59. I think my buttocks are too large.
60. I have feelings I can't quite identity.
61. I eat or drink in secrecy.
62. I think my hips are just the right size.
63. I have extremely high goals.
64. When I am upset, I worry that I will start eating.
65. People I really like end up disappointing me.
66. I am ashamed of my human weaknesses.
67. Other people would say that I am emotionally unstable.
68. I would like to be in total control of my bodily urges.
69. I feel relaxed in most group situations.
70. I say things impulsively that I regret having said.
71. I go out of my way to experience pleasure.
72. I have to be careful of my tendency to abuse drugs.
73. I am outgoing with most people.
74. I feel trapped in relationships.
75. Self-denial makes me stronger spiritually.
76. People understand my real problems.
77. I can't get strange thoughts out of my head.
78. Eating for pleasures a sign of moral weakness.
79. I am prone to outbursts of anger or rage.
80. I feel that people give me the credit I deserve.
81. I have to be careful of my tendency to abuse alcohol.
82. I believe that relaxing is a waste of time.
83. Others would say that I get irritated easily.
84. I feel like I am losing out everywhere.
85. I experience marked mood shifts.
86. I am embarrassed about my bodily urges.
87. I would rather spend time by myself than with others.
88. Suffering makes you a better person.
89. I know that people love me.
90. I feel like I must hurt myself or others.
91. I feel that I really know who I am.

EDI-2 ANSWER SHEET

Name:

A=ALWAYS U=USUALLY O=OFTEN S=SOMETIMES R=RARELY N=NEVER

1	A U O S R N	20	A U O S R N	39	A U O S R N	58	A U O S R N	76	A U O S R N
2	A U O S R N	21	A U O S R N	40	A U O S R N	59	A U O S R N	77	A U O S R N
3	A U O S R N	22	A U O S R N	41	A U O S R N	60	A U O S R N	78	A U O S R N
4	A U O S R N	23	A U O S R N	42	A U O S R N	61	A U O S R N	79	A U O S R N
5	A U O S R N	24	A U O S R N	43	A U O S R N	62	A U O S R N	80	A U O S R N
6	A U O S R N	25	A U O S R N	44	A U O S R N	63	A U O S R N	81	A U O S R N
7	A U O S R N	26	A U O S R N	45	A U O S R N	64	A U O S R N	82	A U O S R N
8	A U O S R N	27	A U O S R N	46	A U O S R N			83	A U O S R N
9	A U O S R N	28	A U O S R N	47	A U O S R N	65	A U O S R N	84	A U O S R N
10	A U O S R N	29	A U O S R N	48	A U O S R N	66	A U O S R N	85	A U O S R N
11	A U O S R N	30	A U O S R N	49	A U O S R N	67	A U O S R N	86	A U O S R N
12	A U O S R N	31	A U O S R N	50	A U O S R N	68	A U O S R N	87	A U O S R N
13	A U O S R N	32	A U O S R N	51	A U O S R N	69	A U O S R N	88	A U O S R N
14	A U O S R N	33	A U O S R N	52	A U O S R N	70	A U O S R N	89	A U O S R N
15	A U O S R N	34	A U O S R N	53	A U O S R N	71	A U O S R N	90	A U O S R N
16	A U O S R N	35	A U O S R N	54	A U O S R N	72	A U O S R N	91	A U O S R N
17	A U O S R N	36	A U O S R N	55	A U O S R N	73	A U O S R N		
18	A U O S R N	37	A U O S R N	56	A U O S R N	74	A U O S R N		
19	A U O S R N	38	A U O S R N	57	A U O S R N	75	A U O S R N		

Name.

The following questions are concerned with the way you feel or act. They are all simple. Please tick the answers that apply to you. Don't spend long on any one question.

1. Do you often feel upset for no obvious reason? Yes..... No.....
2. Do you have an unreasonable fear of being in enclosed spaces such as shop, lifts etc?
   Often..... Sometimes..... Never.....
3. Do people ever say you are too conscientious? No..... Yes.....
4. Are you troubled by dizziness or shortness of breath?
   Never..... Often..... Sometimes.....
5. Can you think as quickly as you used to? Yes..... No.....
6. Are your opinions easily influenced? Yes..... No.....
7. Have you felt as though you might faint? Frequently..... Occasionally..... Never.....
8. Do you find yourself worrying about getting some incurable illness?
   Never..... Sometimes..... Often.....
9. Do you think that "cleanliness is next to godliness?" No..... Yes.....
10. Do you often feel sick or have indigestion? Yes..... No.....
11. Do you feel that life is too much effort? At times..... Often..... Never.....
12. Have you, at any time in your life, enjoyed acting? Yes..... No.....
13. Do you feel uneasy and restless? Frequently..... Sometimes..... Never.....
14. Do you feel more relaxed indoors? Definitely..... Sometimes..... Not particularly.....
15. Do you find that silly or unreasonable thoughts keep recurring in your mind?
   Frequently..... Sometimes..... Never.....
16. Do you sometimes feel tingling or pricking sensations in your body, arms or legs?
   Rarely..... Frequently..... Never.....
17. Do you regret much of your past behaviour? Yes..... No.....
18. Are you normally an excessively emotional person? Yes..... No.....
19. Do you sometimes feel really panicky? No..... Yes.....
20. Do you feel uneasy travelling on buses or the underground even if they are not crowded?
   Very..... A little..... Not at all.....
21. Are you happiest when you are working? Yes..... No.....
22. Has your appetite got less recently? No..... Yes.....
23. Do you wake unusually early in the morning? Yes..... No.....
24. Do you enjoy being the center of attention? No..... Yes.....
25. Would you say you were a worrying person? Very..... Fairly..... Not at all.....
26. Do you dislike going out alone? Yes..... No.....
27. Are you are perfectionist? No..... Yes
28. Do you feel unduly tired and exhausted? Often..... Sometimes..... Never.....
29. Do you experience long periods of sadness?
   Never..... Often..... Sometimes.....

30. Do you find that you take advantage of circumstances for your own ends?

Never..... Sometimes..... Often.....

31. Do you often feel "strung-up" inside? Yes..... No.....

32. Do you worry unduly when relatives are late coming home? No.....Yes.....

33. Do you have to check things you do to an unnecessary extent? Yes.....No.....

34. Can you get off to sleep alright at the moment? No..... Yes.....

35. Do you have to make a special effort to face up to a crisis or difficulty?

Very much so..... Sometimes..... Not more than anyone else.....

36. Do you often spend a lot of money on clothes? Yes..... No.....

37. Have you ever had the feeling you were "going to pieces?" Yes..... No.....

38. Are you scare of heights? Very.....Fairly..... Not at all.....

39. Does it irritate you if your normal routine is disturbed?

Greatly..... A little..... Not at all.....

40. Do you often suffer from excessive sweating or fluttering of the heart? No..... Yes.....

41. Do you find yourself needing to cry? Frequently..... Sometimes..... Never.....

42. Do you enjoy dramatic situations? Yes..... No.....

43. Do you have bad dreams which upset you when you wake up?

Never..... Sometimes..... Frequently.....

44. Do you feel panicky in crowds? Always..... Sometimes..... Never.....

45. Do you find yourself worrying unreasonably about things that do not really matter?

Never..... Sometimes..... Frequently.....

46. Has your sexual interest altered? Less..... The same or greater.....

47. Have you lost your ability to feel sympathy for other people? No..... Yes.....

48. Do you sometimes find yourself posing or pretending? Yes..... No.....

Beck Inventory

Name _____

On this questionnaire are groups of statements. Please read each group of statements carefully. Then pick out the one statement in each group which best describes the way you have been feeling the PAST WEEK, INCLUDING TODAY! Circle the number beside the statement you picked. If several statements in the group seem to apply equally well, circle each one. Be sure to read all the statements in each group before making your choice.

1. 0 I do not feel sad
   1 I feel sad.
   2 I feel sad all the time and I can't snap out of it.
   3 I am so sad or unhappy that I can't stand it.

2. 0 I am not particularly discouraged about the future.
   1 I feel discouraged about the future.
   2 I feel I have nothing to look forward to.
   3 I feel that the future is hopeless and that things cannot improve.

3. 0 I do not feel like a failure.
   1 I feel I have failed more than the average person.
   2 As I look back on my life, all I can see is a lot of failures.
   3 I feel I am a complete failure as a person.

4. 0 I get as much satisfaction out of things as I used to.
   1 I don't enjoy thins the way I used to.
   2 I don't get real satisfaction out of anything anymore.
   3 I am dissatisfied or bored with everything.

5. 0 I don't feel particularly guilty.
   1 I feel guilty a good part of the time.
   2 I feel guilty most of the time.
   3 I feel guilty all of the time.

6. 0 I don't feel I am being punished.
   1 I feel I may be punished.
   2 I expect to be punished.
   3 I feel I am being punished.

7. 0 I don't feel disappointed in myself.
   1 I am disappointed in myself.
   2 I am disgusted with myself.
   3 I hate myself.

8. 0 I don't feel I am any worse than anybody else.
   1 I am critical of myself for my weaknesses or mistakes
   2 I blame myself all the time for my faults.
   3 I blame myself for everything bad that happens.

9. 0 I don't have any thoughts of killing myself.
   1 I have thoughts of killing myself, but I would not carry them out.
   2 I would like to kill myself.
   3 I would kill myself if I had the chance.

10. 0 I don't cry anymore that usual.
    1 I cry more now than I used to.
    2 I cry all the time now,
    3 I used to be able to cry, but now I can't cry even though I want to.

11. 0 I am no more irritated now than I ever am.
    1 I get annoyed or irritated more easily than I used to.
    2 I feel irritated all the time now.
    3 I don't get irritated at all by the things that used to irritate me.

12. 0 I have not lost interest in other people.
    1 I am less interested in other people than I used to be.
    2 I have lost most of my interest in other people.
    3 I have lost all my interest in other people.

13. 0 I make decisions about as well as I ever could.
    1 I put off making decisions more than I used to.
    2 I have greater difficulty in making decisions than before.
    3 I can't make decisions at all anymore.

14. 0 I don't feel I look worse than I used to.
    1 I am worried that I am looking old or unattractive.
    2 I feel that there are permanent changes in my appearances that make me look unattractive.
    3 I believe that I look ugly.

15. 0 I can work about as well as before.
    1 IT takes an extra effort to get started at doing something.
    2 I have to push myself very hard to do anything.
    3 I can't do any work at all.

16. 0 I can sleep as well as usual.
    1 I don't sleep as well as I used to.
    2 I wake up 1-2 hours earlier than usual and find it hard to get back to sleep.
    3 I wake up several hours earlier than I used to and cannot get back to sleep.

17. 0 I don't get more tired than usual.
    1 I get tired more easily than I used to.
    2 I get tired from doing almost anything.
    3 I am too tired to do anything.

18. 0 My Appetite is no worse than usual.
    1 My appetite is not as good as it used to be.
    2 My appetite is much worse now.
    3 I have no appetite at all anymore.

19. 0 I haven't lost much weight if any lately.
    1 I have lost more than 5 pounds.
    2 I have lost more than 10 pounds.
    3 I have lost more than 15 pounds.

    I am purposely trying to lose weight by Eating less. Yes_____ NO_____

20. 0 I am no more worried about my health than usual.
    1 I am worried about physical problems such as aches and pains; or upset stomach; or constipation.
    2 I am very worried about physical problems and it's hard to think of much else.
    3 I am so worried about my physical problems, and I cannot think about anything else.

21. 0 I have not noticed any recent change in my interest in sex.
    1 I am less interested in sex than I used to be.
    2 I am mush less interested in sex now.
    3 I have lost interest in sex completely.

BAI

AME _____ DATE _____

low is a list of common symptoms of anxiety. Please carefully read each item in the list. Indicate how much you have been bothered by each motom during the PAST WEEK, INCLUDING TODAY, by placing an X in the corresponding space in the column next to each symptom.

	NOT AT ALL	MILDLY It did not bother me much.	MODERATELY It was very unpleasant but I could stand it.	SEVERELY I could barely stand it.
1. Numbness or tingling.				
2. Feeling hot.				
3. Wobbliness in legs.				
4. Unable to relax.				
5. Fear of the worst happening.				
6. Dizzy or lightheaded.				
7. Heart pounding or racing.				
8. Unsteady.				
9. Terrified.				
10. Nervous.				
11. Feelings of choking.				
12. Hands trembling.				
13. Shaky.				
14. Fear of losing control.				
15. Difficulty breathing.				
16. Fear of dying.				
17. Scared.				
18. Indigestion or discomfort in abdomen.				
19. Faint.				
20. Face flushed.				
21. Sweating (not due to heat).				

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19 20 21 22 23 24 25 A B C D E
09018425

NAME _____

Emotional Eating Scale

We all respond to different emotions in different ways. Some types of feelings lead people to experience an urge to eat. Please indicate the extent to which the following feelings lead you to feel an urge to eat by checking the appropriate box.

	No Desire to Eat	A Small Desire to Eat	A Moderate Desire to Eat	A Strong Urge to Eat	An Overwhelming Urge to Eat
Resentful					
Discouraged					
Shaky					
Worn Out					
Inadequate					
Excited					
Rebellious					
Blue					
Jittery					
Sad					
Uneasy					
Irritated					
Jealous					
Worried					
Frustrated					
Lonely					
Furious					
On edge					
Confused					
Nervous					
Angry					
Guilty					
Bored					
Helpless					
Upset					

COPE

Name:.....

Date:..... Record Number:.....

We are interested in how people respond when they confront difficult or stressful events in their lives. There are lots of ways to try to deal with stress. This questionnaire asks you to indicate what you generally do and feel when you experience stressful events. Obviously, different events bring out somewhat different responses, but think about what you usually do when you are under a lot of stress.

Then respond to each of the following items by choosing one number for each, using the response choices listed just below.

1 = I usually don't do this at all.	2 = I usually do this a little bit.
3 = I usually do this a medium amount.	4 = I usually do this a lot.

Please try to respond to each item separately in your mind from each other item. Choose your answers thoughtfully, and make your answers as true FOR YOU as you can. Please answer every item. There are no 'right' or 'wrong' answers, so choose the most accurate answer for YOU – not what you think 'most people' would say or do. Indicate what YOU usually do when YOU experience a stressful event.

1. I try to grow as a person as a result of the experience. ☐
2. I turn to work or other substitute activities to take my mind off things. ☐
3. I get upset and let my emotions out. ☐
4. I try to get advice from someone about what to do. ☐
5. I concentrate my efforts on doing something about it. ☐
6. I say to myself "this isn't real". ☐
7. I put my trust in God. ☐
8. I laugh about the situation. ☐
9. I admit to myself that I can't deal with it, and give up trying. ☐
10. I restrain myself from doing anything too quickly. ☐

11. I discuss my feelings with someone. ☐
12. I use alcohol or drugs to make myself feel better. ☐
13. I get used to the idea that it happened. ☐
14. I talk to someone to find out more about the situation. ☐
15. I keep myself from getting distracted by other thoughts or activities. ☐
16. I daydream about things other than this. ☐
17. I get upset, and am really aware of it. ☐
18. I seek God's help. ☐
19. I make a plan of action. ☐
20. I make jokes about it. ☐

2

21. I accept that this has happened and that it can't be changed. ☐
22. I hold off doing anything about it until the situation permits. ☐
23. I try to get emotional support from friends and relatives. ☐
24. I just give up trying to reach my goal. ☐
25. I take additional action to try to get rid of the problem. ☐
26. I try to lose myself for a while by drinking alcohol or taking drugs. ☐
27. I refuse to believe that it has happened. ☐
28. I let my feelings out. ☐
29. I try to see it in a different light, to make it seem more positive. ☐
30. I talk to someone who could do something concrete about the problem. ☐

31. I sleep more than usual. ☐
32. I try to come up with a strategy about what to do. ☐
33. I focus on dealing with this problem and, if necessary, let other things slide a little. ☐
34. I get sympathy and understanding from someone. ☐
35. I drink alcohol or take drugs, in order to think about it less. ☐
36. I kid around about it. ☐
37. I give up the attempt to get what I want. ☐
38. I look for something good in what is happening. ☐
39. I think about how I might best handle the problem. ☐
40. I pretend that it hasn't really happened. ☐

41. I make sure not to make matters worse by acting too soon. ☐
42. I try hard to prevent other things from interfering with my efforts at dealing with this. ☐
43. I go to the cinema or watch television, to think about it less. ☐
44. I accept the reality of the fact that it happened. ☐
45. I ask people who have had similar experiences what they did. ☐
46. I feel a lot of emotional distress and I find myself expressing those feelings a lot. ☐
47. I take direct action to get around the problem. ☐
48. I try to find comfort in my religion. ☐
49. I force myself to wait for the right time to do something. ☐
50. I make fun of the situation. ☐

51. I reduce the amount of effort I'm putting into solving the problem. ☐
52. I talk to someone about how I feel. ☐
53. I use alcohol or drugs to help me get through it. ☐
54. I learn to live with it. ☐
55. I put aside other activities in order to concentrate on this. ☐
56. I think hard about what steps to take. ☐
57. I act as though it hasn't even happened. ☐
58. I do what has to be done, one step at a time. ☐
59. I learn something from the experience. ☐
60. I pray more than usual. ☐

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The General Health Questionnaire NAME _____

Please read this carefully

We should like to know if you have had any medical complaints, and how your health has been in general, *over the past few weeks*. Please answer ALL the questions on the following pages simply by underlining the answer which you think most nearly applies to you. Remember that we want to know about present and recent complaints, not those that you had in the past.

It is important that you try to answer ALL the questions.
Thank you very much for your co-operation.

HAVE YOU RECENTLY:

1 - *been feeling perfectly well and in good health?*	Better than usual	Same as usual	Worse than usual	Much worse than usual
2 – *been feeling in need of a good tonic?*	Not at all	No more than usual	Rather more than usual	Much more than usual
3 – *been feeling run-down and out of sorts?*	Not at all	No more than usual	Rather more than usual	Much more than usual
4 – *felt that you are ill?*	Not at all	No more than usual	Rather more than usual	Much more that usual
5 – *been getting any pains in your head?*	Not at all	No more than usual	Rather more than usual	Much more that usual
6 – *been getting a feeling of tightness or pressure in your head?*	Not at all	No more than usual	Rather more than usual	Much more than usual.
7 – *been able to concentrate on whatever you're doing?*	Better than usual	Same as usual	Less than usual	Much less than usual
8 – *been afraid that you were going to collapse in a public place?*	Not at all	No more than usual	Rather more than usual	Much more than usual
9 – *been having hot or cold spells?*	Not at all	No more than usual	Rather more than usual	Much more than usual
10 – *been perspiring (sweating) a lot?*	Not at all	No more than usual	Rather more than usual	Much more than usual
11 – *found yourself waking early and unable to get back to sleep*	Not at all	No more than usual	Rather more than usual	Much more than usual
12 – *been getting up feeling your sleep hasn't refreshed you?*	Not at all	No more than usual	Rather more than usual	Much more than usual
13 – *been feeling too tired and exhausted even to eat?*	Not at all	No more than usual	Rather more than usual	Much more than usual
14 – *lost much sleep over worry?*	Not at all	No more than usual	Rather more than usual	Much more than usual
15 – *been feeling mentally alert and wide awake?*	Better than usual	Same as usual	Less alert than usual	Much less alert
16 – *been feeling full of energy?*	Better than usual	Same as usual	Less energy than usual	Much less energy
17 – *had difficulty in getting off to sleep?*	Not at all	No more than usual	Rather more than usual	Much more than usual

HAVE YOU RECENTLY:

18 – *had difficulty in staying asleep once you are off?*	Not at all	No more than usual	Rather more than usual	Much more than usual
19 – *been having frightening or unpleasant dreams?*	Not at all	No more than usual	Rather more than usual	Much more than usual
20 – *been having restless, disturbed nights?*	Not at all	No more than usual	Rather more than usual	Much more than usual
21 – *been managing to keep yourself busy and occupied?*	More so than usual	Same as usual	Rather less than usual	Much less than usual
22 – *been taking longer over the things you do?*	Quicker than usual	Same as usual	Longer than usual	Much longer than usual
23 – *tended to lose interest in your ordinary activities?*	Not at all	No more than usual	Rather more than usual	Much more than usual
24 – *been losing interest in your personal appearance?*	Not at all	No more than usual	Rather more than usual	Much more than usual
25 - *been taking less trouble with your clothes?*	More trouble than usual	About same as usual	Less trouble than usual	Much less trouble
26 – *been getting out of the house as much as usual?*	More than usual	Same as usual	Less than usual	Much less than usual
27 – *been managing as well as most people would in your shoes?*	Better than most	About the same	Rather less well	Much less well
28 – *felt on the whole you were doing things well?*	Better than usual	About the same	Less well than usual	Much less well
29 – *been late getting to work, or getting started on your housework?*	Not at all	No later than usual	Rather later than usual	Much later than usual
30 – *been satisfied with the way you've carried out your task?*	More satisfied	About same as usual	Less satisfied than usual	Much less satisfied
31 – *been able to feel warmth and affection for those near you?*	Better than usual	About same as usual	Less well than usual	Much less well
32 – *been finding it easy to get on with other people?*	Better than usual	About same as us	Less well than usual	Much less well
33 – *spent much time chatting with people?*	More time than usual	About same as usual	Less than usual	Much less than usual
34 – *kept feeling afraid to say anything to people in case you make a fool of yourself?*	Not at all	No more than usual	Rather more than usual	Much more than usual
35 – *felt that you are playing a useful part in things?*	More so than usual	Same as usual	Less useful than usual	Much less useful
36 - *felt capable of making decisions about things?*	More so than usual	Same as usual	Less so than usual	Much less capable
37 – *felt you're just not able to make a start on anything?*	Not at all	No more than usual	Rather more than usual	Much more than usual

HAVE YOU RECENTLY:

38 – *felt yourself dreading everything? that you have to do?*	Not at all	No more than usual	Rather more than usual	Much more than usual
39 – *felt constantly under strain?*	Not at all	No more than usual	Rather more than usual	Much more than usual
40 – *felt you couldn't overcome you difficulties?*	Not at all	No more than usual	Rather more than usual	Much more than usual
41 – *been finding life a struggle all the time?*	Not at all	No more than usual	Rather more than usual	Much more than usual
42 – *been able to enjoy your normal day-to-day activities?*	More so than usual	Same as usual	Less so than usual	Much less so than usual
43 – *been taking things hard?*	Not at all	No more than usual	Rather more than usual	Much more than usual
44 – *been getting edgy and bad-tempered?*	Not at all	No more than usual	Rather more than usual	Much more than usual
45 – *been getting scared or panicky for no good reason?*	Not at all	No more than usual	Rather more than usual	Much more than usual
46 – *been able to face up to your problems?*	More so than usual	Same as usual	Less able than usual	Much less able
47 – *found everything getting on top of you?*	Not at all	No more than usual	Rather more than usual	Much more than usual
48 – *had the feeling that people were looking at you?*	Not at all	No more than usual	Rather more than usual	Much more than usual
49 – *been feeling unhappy and depressed?*	Not at all	No more than usual	Rather more than usual	Much more than usual
50 – *been losing confidence in yourself?*	Not at all	No more than usual	Rather more than usual	Much more than usual
51 – *been thinking of yourself as a worthless person?*	Not at all	No more than usual	Rather more than usual	Much more than usual
52 – *felt that life is entirely hopeless?*	Not at all	No more than usual	Rather more than usual	Much more than usual
53 – *been feeling hopeful about your own future?*	More so than usual	About same as usual	Less so than usual	Much less hopeful
54 – *been feeling reasonably happy, all things considered?*	More so than usual	About same as usual	Less so than usual	Much less than usual
55 – *been feeling nervous and strung-up all the time?*	Not at all	No more than usual	Rather more than usual	Much more than usual
56 – *felt that life isn't worth living?*	Not at all	No more than usual	Rather more than usual	Much more than usual
57 – *thought of the possibility that you might make away with yourself?*	Definitely not	I don't think so	Has crossed my mind	Definitely have
58 – *found at times you couldn't do anything because your nerves were too bad?*	Not at all	No more than usual	Rather more than usual	Much more than usual
59 – *found yourself wishing you were dead and away from it all?*	Not at all	No more than usual	Rather more than usual	Much more than usual
60 – *found that the idea of taking your own life kept coming into your mind?*	Definitely not	I don't think so	Has crossed my mind	Definitely has

APPENDIX 3
INFORMATION SHEET AND CONSENT FORM

Department of Psychology

Information sheet

You are invited to participate in a research project on eating and emotions by completing the following questionnaires. If at any time you decide to withdraw your participation, you should stop filling out the questionnaire and it will be destroyed. By completing the questionnaire, however, it will be understood that you have consented to participate in this stage of the project. If you continue as a participant in the project it is understood that you consent to possible publication of the results of the project with the understanding that anonymity will be preserved.

Consent form

I have read and understood the above information. On this basis I agree to continue to participate in this project, and I consent to publication of the results of the project with the understanding that anonymity will be preserved. I understand also that I may at any time withdraw from the project, including withdrawal of any information I have provided.

Signed Date

This project has been approved by the University of Canterbury Human Ethics Committee and is being carried out by Natasha Wallis (under the supervision of Neville Blampied), as required for a Masters Degree in Psychology

Department of Psychology

The questionnaires that you just filled out will be used to assess whether you suffer from a problem technically know as binge eating disorder. We need participants to take part in a programme for binge eating disorder that focuses on identifying and managing emotions. Being involved as a participant would require 2 hours a week of your time for 8 weeks.

I have read and understood the above information. If I have binge eating disorder I would/would not be interested in having information sent out to me about the program.

If you are interested in having information sent out about the programme please write your details below.

Name Address Contact No

This project has been approved by the University of Canterbury Human Ethics Committee and is being carried out by Natasha Wallis (under the supervision of Neville Blampied), as required for a Masters Degree in Psychology.

APPENDIX 4
ADVERTISEMENT

EATING AND EMOTIONS

Department of Psychology

Female participants are wanted for research investigating eating and emotions. Your involvement in this research will involve filling out 2 short questionnaires and you maybe invited back to participate in more research involving small group activities.

Christian Name Contact Phone No

This project has been approved by the University of Canterbury Human Ethics Committee and is being carried out by Natasha Wallis (under the supervision on Neville Blampied), as required for a Masters Degree in Psychology.

APPENDIX 5
MIDDLESEX HOSPITAL QUESTIONNAIRE RESULTS

Means and Standard Deviations on the Middlesex Hospital Questionnaire for the Programme and Control Group and a Healthy Sample For Comparison.

	Programme						Control						Healthy*	
	Before		After		Follow-up		Before		After		Follow-up			
6 factors	Mean	Std	Mean	Std	Mean	Std	Mean	Std	Mean	Std	Mean	Std	Mean	Std
Anxiety	13.3	5	14.7	2.3	9.3	5.5	14	3	13.7	3.5	14.7	1.1	5.86	3.3
Phobic	9.7	4	6.7	5.9	6.3	5.5	13.7	4.2	12	2	12.3	5	4.51	2.7
Obsessional	11.3	4.6	10	5.3	10.3	5.5	12.7	3	13.7	3.2	10.7	3.5	6.19	3
Somatic	7.3	3	6	1.7	5.7	1.5	11.3	1.2	12.3	2.1	8.7	2.5	3.12	2.3
Depression	9.3	1.5	9.3	1.2	8.3	1.5	12.3	4	12	4	11	1.7	3.18	2.3
Hysteria	8.7	1.2	8	3.5	7.3	1.1	6.7	1.2	6	0	8.7	3	6.17	3.3
Total Mean & Std Scores	59.3	10.2	54.7	7	47.3	13	70.7	11.2	68.3	9	66	5	29.24	10.9

* Healthy sample taken from Bagley (1980).

APPENDIX 6
PROGRAMME EVALUATION FORMS

Programme Evaluation

1. Have you enjoyed the programme?

1-------2-------3--------4-------(5)----6-------7
not very much very much

- What did you enjoy about the programme?
- What did you not enjoy about the programme?

Meeting other people who did the same things I do and think the same
Getting strategies to help.
Having to come in during exam time. (not a biggy)

2. Did you find the programme helpful?

1-------2-------3--------4--------5-----(6)----7
not very helful very helpful

-If yes, in what way?

It made me more relaxed about eating and helped me recognise emotions that led me to binge.

3. What aspect/s of the programme did you find of most use?

Emotion recognition
Assertiveness training
Problem solving.

4. What aspect/s of the programme did you find of little use?

I thought it was all good.

5. Do you feel differently about your binge eating now, as opposed to before the programme?

1-------2-------3------(4)------5-------6-------7

very little difference — much differently

- If yes, if what way?

That it is not completely out of control. I can do something about it but I think it will take a long time.

6. What improvements do you think could be made to the programme?

More group discussion, less writing I learn more from talking with others.

Maybe put some of the lessons together

7. How do you feel now that you have completed the programme?

Determined to get it under control + recognise how I'm feeling and do something about it. Be more assertive.

8. Would you recommend the programme to a friend?

Yes.

9. Any other comments

Programme Evaluation

1. Have you enjoyed the programme?

1-------2-------3--------4--------5-------(6)-------7
not very much very much

-What did you enjoy about the programme?
-What did you not enjoy about the programme?

- I enjoyed the relaxed nature and the feeling of "I'm not the only one".
- Natasha reading from OHP (sometimes... although can understand that it ensures one reads it.)

2. Did you find the programme helpful?

1-------2-------3--------4-------(5)------6-------7
not very helful very helpful

-If yes, in what way?

- Identifying my emotions-
- recognizing links between not being expressive & binging.

3. What aspect/s of the programme did you find of most use?

Trying to recognise emotions
Writing exercise.

4. What aspect/s of the programme did you find of little use?

/

5. Do you feel differently about your binge eating now, as opposed to before the programme?

1-------2-------3--------4--------5--------6-------7
very little difference — much differently

- If yes, if what way?

I feel I can identify why I binge more than before.
I know that not all food is a binge. - It's okay to snack 2 x a day.

6. What improvements do you think could be made to the programme?

Asking what our opinions were before telling us what "~~sleeper~~ experts" say.

~~[illegible]~~ More time for discussion - sometimes . . .

7. How do you feel now that you have completed the programme?

I feel like I have more valuable tools to help me ~~lose~~ lose weight. This is FAR better than any other "Diet Factory" type affair - Feelings & emotions are the cause - this addressed it for me.

8. Would you recommend the programme to a friend?

yes.

9. Any other comments

I think I really benefitted from this course. It is so important to realise I am not the only one who binges.

I did enjoy it.

Programme Evaluation

1. Have you enjoyed the programme?

1-------2-------3--------4--------5------(6)-----7
not very much very much

-What did you enjoy about the programme?
-What did you not enjoy about the programme?

-meeting others who could relate to what I feel at time and who understood the feeling of lack of control or no control when it comes to binging.

2. Did you find the programme helpful?

1-------2-------3--------4------(5)----6-------7
not very helful very helpful

-If yes, in what way?

- understanding emotions
- relaxation
- problems solving
- assertiveness assertion

3. What aspect/s of the programme did you find of most use?

-the comment that it's normal to feel full

4. What aspect/s of the programme did you find of little use?

5. Do you feel differently about your binge eating now, as opposed to before the programme?

1-------2-------3--------4------(5)----6-------7
very little difference much differently

- If yes, if what way?

- I can understand why I'm bingeing at times
- I can recognise my emotions more now.

6. What improvements do you think could be made to the programme?

7. How do you feel now that you have completed the programme?

Good but concerned I won't cope by myself so well.
It was good to talk to people who could relate or even understand and believe that you do have a problem.

8. Would you recommend the programme to a friend?

Yes.

9. Any other comments

APPENDIX 7
ETHIC COMMITTEE APPROVAL LETTER

University of Canterbury Private Bag 4800
Christchurch New Zealand
Telephone: 03-366 7001
Fax: 03-364 2999

17 July 1998

Ms Natasha Wallis
C/o Mr N Blampied
Department of Psychology
UNIVERSITY OF CANTERBURY

Dear Ms Wallis

The Human Ethics Committee advises that your research proposal **"Treating Binge Eating Disorder: a Psychoeduational Group Programme Teaching Emotional Discrimination and Management"** has been considered and approved subject to the receipt by the HEC Secretary of revised documents bearing the name of the department and the researchers.

Yours sincerely

Isobel Phillips
Secretary